

Fire Service Exposure Report

FDID	FIRE DEPARTMENT	INCIDENT NO.	MO	DA	YR
TIME	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NO.	SEX 1 - MALE <input type="checkbox"/> 2 - FEMALE <input type="checkbox"/>		AGE

<input type="checkbox"/> INCIDENT TYPE 1. Residential Fire 2. Trash/Dumpster 3. Industrial Fire 4. Marine Fire 5. Vehicle Fire 6. Explosion 7. Spill 8. Commercial Fire 9. Rescue	<input type="checkbox"/> RIDING ASSIGNMENT 1. Tanker 2. Engine 3. Squad Car 4. Car 5. Ambulance 6. HazMat 7. Ladder Co.	<input type="checkbox"/> RANK 1. Firefighter 2. Lieutenant 3. Captain 4. Chief Officer 5. Other
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<input type="checkbox"/> LENGTH OF EXPOSURE <input type="checkbox"/> FIRE STAGE 1. Incipient 2. Free Burning 3. Smoldering 4. Nonfire Incident <input type="checkbox"/> ACTIVITY 1. Extinguishment 2. Entry/Ventilation 3. Rescue 4. Overhaul 5. EMS 6. Investigation <input type="checkbox"/> TIME 1. 1 Hour 2. 2 Hours 3. 3 Hours 4. 3+ Hours	<input type="checkbox"/> CONDITIONS OF MATERIAL 1. Solid 2. Liquid 3. Gas 4. Inside Burning 5. Outdoors 6. Dust 7. Mist 8. Reactive with Other Substances 9. Radioactive	<input type="checkbox"/> TYPE OF EXPOSURE 1. Inhalation 2. Ingestion 3. Skin Contact 4. Eye Contact 5. At the Scene, No Known Contact <input type="checkbox"/> SMOKE CONDITION DURING EXPOSURE 1. Light 2. Heavy 3. None
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SYMPTOMS

<input type="checkbox"/> AT INCIDENT 1. Eyes Burn 2. Cough 3. Cuts/Bruises	<input type="checkbox"/> AFTER INCIDENT 4. Nose/Lung Irritation 5. Dizzy/Nausea 6. Ears Ringing 7. Headache 8. Skin Irritation/Rash 9. Unconscious
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Were you supplied with special equipment for the incident? Yes No

Were special decontamination procedures followed after exposure? Yes No

Did you receive medical evaluation or treatment after exposure? Yes No

DIAGNOSIS
 1. Smoke Inhalation 2. Contact Dermatitis 3. Respiratory Tract Irritation 4. Cuts/Bruises

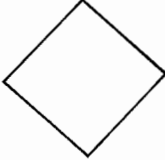
DOCTOR/TREATMENT FACILITY

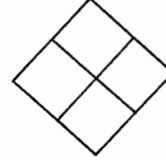
DESCRIPTION OF TOXIC SUBSTANCE(S) (IF KNOWN)

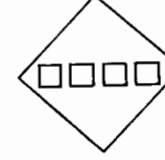
Trade Name _____ Ingredients _____
 Chemical Name _____ Manufacturer _____

Did substance have a label/placard? Yes No

LIST INFORMATION ON LABEL (i.e., I.D. NUMBER) IF KNOWN:


 Domestic Label


 704 - System


 UN or DOT System

CONTAGIOUS DISEASE INFORMATION

During Rescue or EMS Response, was victim bleeding? Yes No
 Did you have any cuts or bruises on your hands or body? Yes No

REMARKS
