PERSONAL EXPOSURE RECORDING SYSTEM

EXPOSURE REPORT FORM Name _____ (1) Social Security Number _____

(1A) Local Union # _____ (2) Incident Date _____ (3) Alarm Time _____ (4) Incident Time _____

I. (5) INCIDENT OR EXPOSURE TYPE (check one)

(1) ☐ **Residential Fire** **(2)** ☐ **Industrial Fire** **(3)** ☐ **Vehicle Fire** **(4)** ☐ **Commercial Fire** **(5)** ☐ **Wildland Fire**

(6) ☐ **Trash/Dumpster** **(7)** ☐ **Marine Fire** **(8)** ☐ **Explosion** **(9)** ☐ **Medical Aid/Rescue** **(10)** ☐ **Haz-Mat**

(11) Other (describe in one or two words) _____

(6) More detail on type of structure (single family, firehouse, etc…) _____

II. LENGTH OF EXPOSURE BY FIRE STAGE / ACTIVITY

Fire Stage:	Mins/Hrs exposed (Please Write In)
(7) Incipient	
(8) Free Burning	
(9) Smoldering	
(10) Non-Fire Incident	

Activity:	Mins/Hrs exposed (Please Write In)
(11) Extinguishment	
(12) Entry/Ventilation	
(13) Rescue/Extrication	
(14) Light Overhaul	
(15) Heavy Overhaul	
(16) E.M.S.	
(17) Investigation	

III. SMOKE/CHEMICAL/MEDICAL EXPOSURE

(18) Smoke condition: (L) ☐ Light (H) ☐ Heavy (N) ☐ None (19) Smoke Colors) _____

	Chemicals) Present	Vapor/Gas	Dust	Heavy Mist	Light Mist	Combust Prod	Solid/Powder	Comments
(20)								
(21)								
(22)								
(23)								

(24) Medical Exposure: ☐ HIV ☐ Hepatitis B ☐ Blood ☐ Other: _____

(25) Route of Exposure: (1) ☐ Inhaled (2) ☐ Ingested (3) ☐ Skin Contact (4) ☐ Eye Contact (5) ☐ OPR

IV. SYMPTOMS

	At Incident	Symptom	After Incident
(26)		**Eyes Burn**	
(27)		**Cough**	
(28)		**Cough Blood/Nose Bleed**	
(29)		**Nose/Lung Irritation**	
(30)		**Nausea/Queasiness**	
(31)		**Dizzy**	

	At Incident	Symptom	After Incident
(32)		**Ears Ringing**	
(33)		**Headache**	
(34)		**Skin Irritated/Rash**	
(35)		**Unconscious**	
(36)		**Other:**	

V. MEDICAL DIAGNOSIS

(37) Did you receive medical evaluation or treatment from a medical professional after exposure? ☐ Yes ☐ No

Official Medical Diagnosis: (38) ☐ Smoke Inhalation (39) ☐ Contact Dermatitis (40) ☐ Respiratory Tract Irritation

(41) ☐ Other: _____

Name of Doctor/Treatment Facility: _____

VI. PROTECTIVE EQUIPMENT / DECONTAMINATION

Were you provided with protective equipment for this incident other than that required by OSHA? (SCBA is required) (42) ☐ Yes ☐ No

☐ Chemical Protective Suit ☐ Overhaul Mask ☐ Other: _____

Were decontamination procedures followed after the exposure? (43) ☐ Yes ☐ No

Describe: _____

VII. CO-WORKERS AT TIME OF EXPOSURE

Please list names of other firefighters working close to you at time of exposure. (44) _____

VIII. ADDITIONAL INFORMATION: Were you asleep at the time of alarm? (45) ☐ Yes ☐ No

Other information: (46) _____