



# Exposure Control

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<b>Original Date:</b>	<b>Date Revised:</b>
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All questions contained in this questionnaire are strictly confidential and will become part of your medical record. This is a protected document complying with all applicable Privacy of Information Act standards, HIPA regulations and OSHA 1910.1030. This document must be maintained for the life of the employee plus thirty years. Access to this document is strictly prohibited. Access is only allowed to an authorized department employee and the individual named.

INDIVIDUAL INFORMATION	
<b>Name:</b> (first, last, middle) <span style="float: right;"><input type="checkbox"/> M <input type="checkbox"/> F</span>	<b>DOB:</b>
Division: <input type="checkbox"/> Sheriff <input type="checkbox"/> Police <input type="checkbox"/> Fire Department <input type="checkbox"/> Emergency Management <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer	
<b>Date of Exposure:</b>	<b>Date of last physical exam:</b>

INCIDENT STATISTICS							
<b>How did exposure occur:</b> <input type="checkbox"/> Skin Contact/Absorption <input type="checkbox"/> Inhalation <input type="checkbox"/> Ingestion <input type="checkbox"/> Abrasion <input type="checkbox"/> Injection <input type="checkbox"/> Cut							
<b>Immunizations and Dates</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Tetanus:</td> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Pneumonia:</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Hepatitis:</td> <td style="padding: 5px;"><input type="checkbox"/> Chickenpox:</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Influenza:</td> <td style="padding: 5px;"><input type="checkbox"/> MMR (Measles, Mumps, Rubella):</td> </tr> </table>	<input type="checkbox"/> Tetanus:	<input type="checkbox"/> Pneumonia:	<input type="checkbox"/> Hepatitis:	<input type="checkbox"/> Chickenpox:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> MMR (Measles, Mumps, Rubella):
<input type="checkbox"/> Tetanus:	<input type="checkbox"/> Pneumonia:						
<input type="checkbox"/> Hepatitis:	<input type="checkbox"/> Chickenpox:						
<input type="checkbox"/> Influenza:	<input type="checkbox"/> MMR (Measles, Mumps, Rubella):						

Describe the incident and how it occurred:

What mitigation protocols were in place to avoid this type of exposure?		
<input type="checkbox"/> Semi positive pressure full face mask	<input type="checkbox"/> Surface supplied air system	<input type="checkbox"/> Hand washing
<input type="checkbox"/> Positive pressure full face mask	<input type="checkbox"/> Positive pressure air delivery system	<input type="checkbox"/> Other
<input type="checkbox"/> Dive helmet	<input type="checkbox"/> Fresh water wash down/post dive	<input type="checkbox"/> Other
<input type="checkbox"/> Dry suit w/ hood	<input type="checkbox"/> Antibacterial wash down/post dive	<input type="checkbox"/> Other
<input type="checkbox"/> Dry gloves	<input type="checkbox"/> Diver shower	<input type="checkbox"/> Other

What mitigation protocols were used to avoid this type of exposure?		
<input type="checkbox"/> Semi positive pressure full face mask	<input type="checkbox"/> Surface supplied air system	<input type="checkbox"/> Hand washing
<input type="checkbox"/> Positive pressure full face mask	<input type="checkbox"/> Positive pressure air delivery system	<input type="checkbox"/> Other
<input type="checkbox"/> Dive helmet	<input type="checkbox"/> Fresh water wash down/post dive	<input type="checkbox"/> Other
<input type="checkbox"/> Dry suit w/hood	<input type="checkbox"/> Antibacterial wash down/post dive	<input type="checkbox"/> Other
<input type="checkbox"/> Dry gloves	<input type="checkbox"/> Diver shower	<input type="checkbox"/> Other

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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How long before the effects of exposure were noticed?		
<input type="checkbox"/> During Dive	<input type="checkbox"/> 3 – 7 days after dive	<input type="checkbox"/> 3 – 6 months after dive
<input type="checkbox"/> Immediately After Dive	<input type="checkbox"/> 7 – 14 days after dive	<input type="checkbox"/> 6 – 12 months after dive
<input type="checkbox"/> Within 24 hours after dive	<input type="checkbox"/> 14 – 30 days after dive	<input type="checkbox"/> 1 – 3 years after dive
<input type="checkbox"/> 24 – 72 hours after dive	<input type="checkbox"/> 1 – 3 months after dive	<input type="checkbox"/> 3 – 5 years after dive

**How did the effects present itself?** (Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.)

<input type="checkbox"/> Itch	<input type="checkbox"/> Acne/PUS	<input type="checkbox"/> Drastic changes in weight:
<input type="checkbox"/> Rash	<input type="checkbox"/> Tingling in the extremities	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Lesion	<input type="checkbox"/> Muscle Aches/Pain	<input type="checkbox"/> Headaches
<input type="checkbox"/> Burn	<input type="checkbox"/> Tremors/Body Shakes/Seizures	<input type="checkbox"/> Memory Loss/Mood Changes
<input type="checkbox"/> Blister	<input type="checkbox"/> GID/Diarrhea/Vomiting	<input type="checkbox"/> Other:
<input type="checkbox"/> Discolored Skin Tissue	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Other:

#### IF YOU WERE SEEN BY A PHYSICIAN

<b>Drs. Name:</b> (first, last, middle)	<b>Contact #:</b>	<b>Date of exam:</b>
<b>Address:</b>		
<b>Was prescription issued:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was a diagnosis determined:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Individual's Name:</b> (Last, First, M.I.):	<b>Date:</b>	<b>Recorder Name:</b> (Last, First, M.I.):	<b>Date:</b>
<b>Signature:</b>		<b>Signature:</b>	