EXPOSURE AND INJURY REPORT

Name

Incident Address

Incident Time:

Incident or Call #

Shift / Station

Date Time

Report Time

☐ Seen by Physician

Type of Activity

☐ EMS ☐ Hazmat ☐ US&R ☐ Training ☐ Fitness ☐ Public Service

☐ Fire Ground ☐ Rescue ☐ Station ☐ Motor Vehicle ☐ Active Fire

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○ TOXIC RELEASE

○ RADIATION EXPOSURE

○ METAMPHETAMINE OR DRUG LAB

- ☐ Smoke
- ☐ Airborne/Lungs
- ☐ Ingestion/Oral
- ☐ Skin Contact
- ☐ Eye
- ☐ General Exposure

Chemical Name

○ BLOODBORNE

Nature of Contact

Type of Needle, If any

Type of Fluid

SOURCE PATIENT POSITIVE

☐ Hep B ☐ HIV

☐ Hep C ☐ Source Blood Drawn

○ OTHER BIOLOGIC

Communicable Disease

Biowarfare Agent

- ☐ Electrical
- ☐ Loud Noise
- ☐ Cold Exposure
- ☐ Heat Effect
- ☐ Musculoskeletal
- ☐ Laceration

OTHER

SYMPTOMS ANDSIGNS

- [ ] Headache
- [ ] Dizziness/Nausea
- [ ] Ear Ringing
- [ ] Eye Burning
- [ ] Nosebleed
- [ ] Nose/Throat/Lung
- [ ] Skin Rash / Burn
- [ ] Wound/Muscular
- [ ] Loss of Consciousness
- [ ] None

Additional Information

BODY REGION AFFECTED

- [ ] Eye
- [ ] Ear
- [ ] Airway
- [ ] Heart
- [ ] Face
- [ ] Neck/Back
- [ ] Arm/Hand
- [ ] Skin
- [ ] Trunk
- [ ] Leg/Foot

Enter Specific Location

PERSONAL PROTECTIVE EQUIPMENT USED

Respiratory Protection

Body Protection

Eye Protection

ADDITIONAL ITEMS

DURATION OF EXPOSURE

DECONTAMINATION

TYPE OF MEDICAL CARE

Witness(es)

Medical Facility & Physician Information

- [ ]

Duty Chief

Incident Summary / Additional Info

Signature

CC: Human Resources

CC: On-duty Battalion Chief

Print Form

Menlo Park Fire Protection District

SUPERVISOR'S REPORT OF EMPLOYEE INJURY

Employee Name_____ Date Reported _____

Position _____

Department _____

Was medical treatment required? Yes, and DWC-1 filled out ☐ No ☐

Name/Location of Physician _____

Did the employee return to work? Yes ☐ No ☐ Date last worked_____ Still Off? _____

1. What job was employee doing when injury/exposure occurred?

2. Where did injury/exposure occur?

3. Describe accident and nature of injury/exposure?

4. What unsafe act(s) and/or condition(s) caused the accident?

☐ Excessive or improper lifting	☐ Congested work area
☐ Unsafe clothing or footwear	☐ Unauthorized activity
☐ Unsafe floor or stair condition	☐ Override of safety device
☐ Safety procedure not followed	☐ Unsafe driving
☐ Unstable piling or stacking	☐ Improper use of equipment
☐ Unpreventable	☐ Other _____

5. What can be done to prevent similar accident?

Supervisor Name _____ Date _____

Send to: Human Resources
Keep a copy for your records.