## **EPISODE WITNESS/INJURED/COMPLAINANT REPORT**

PR-ENF-127B (REV. 8/07) PAGE 1 OF 1 **PAGE** OF PRIORITY INVESTIGATION OTHER I.D. NO. COUNTY OF OCCURRENCE DATE OF OCCURRENCE NO YES # DAY COMPLAINT SIGNED WAS DOCTOR VISITED ACTIVITY OF PERSON EXPOSED/INVOLVED EXTENT OF INJURY/ILLNESS Fatal Symptoms Mixer/Loader Field Worker' Other\* YES NO N/A YES NO N/A Exposed Only Applicator Explain NAME AGE SEX WHS NO. NO. OF WORKDAYS LOST ADDRESS CITY ZIP CODE PHONE WITNESS/INJURED/COMPLAINANT MEDICAL FACILITY NAME DATE/TIME ADMITTED DATE/TIME DISCHARGED TREATMENT PROVIDED HOSPITALIZED OBSERVATION ONLY YES PHYSICIAN ADDRESS PHONE SIGNS/SYMPTOMS EXPERIENCED **EMPLOYER** ADDRESS PHONE PROTECTIVE MEASURES USED EYES **HANDS** INHALATION OTHER **ENGINEERING CONTROLS** Safety Glasses Cloth/Leather Gloves Dust Mask Work Clothes 1/2 Face Respirator Enclosed Cab Goggles Chemical Resistant Gloves Coveralls Faceshield Other Full Face Respirator Chemical Resistant Clothes Enclosed Cab w/Air Purification Eye/Sun Glasses None SCBA Chemical Resistant Boots Other None Head Covering None None Other COMPLAINT SIGNED WAS DOCTOR VISITED EXTENT OF INJURY/ILLNESS ACTIVITY OF PERSON EXPOSED/INVOLVED Fatal Mixer/Loader Field Worker' Other Symptoms YES NO N/A YES NO N/A Serious Exposed Only Applicator Public\* Explain NO. OF WORKDAYS LOST NAME AGE SEX WHS NO. ZIP CODE PHONE ADDRESS CITY WITNESS/INJURED/COMPLAINANT MEDICAL FACILITY NAME HOSPITALIZED DATE/TIME ADMITTED DATE/TIME DISCHARGED TREATMENT PROVIDED OBSERVATION ONLY YES NO ADDRESS PHONE PHYSICIAN SIGNS/SYMPTOMS EXPERIENCED ADDRESS PHONE EMPLOYER PROTECTIVE MEASURES USED **ENGINEERING CONTROLS** EYES HANDS INHALATION OTHER Safety Glasses Cloth/Leather Gloves **Dust Mask** Work Clothes Closed System Goggles Chemical Resistant Gloves 1/2 Face Respirator Coveralls **Enclosed Cab** Other Faceshield Full Face Respirator Chemical Resistant Clothes Enclosed Cab w/Air Purification SCBA Eve/Sun Glasses None Chemical Resistant Boots Other None Head Covering None None Other ACTIVITY OF PERSON EXPOSED/INVOLVED COMPLAINT SIGNED WAS DOCTOR VISITED EXTENT OF INJURY/ILLNESS Fatal Symptoms Mixer/Loader Field Worker Other\* YES NO N/A YES NO N/A Serious Exposed Only Applicator Public<sup>2</sup> Explain SEX WHS NO NO. OF WORKDAYS LOST NAME AGE ADDRESS ZIP CODE PHONE CITY WITNESS/INJURED/COMPLAINANT HOSPITALIZED DATE/TIME ADMITTED DATE/TIME DISCHARGED MEDICAL FACILITY NAME TREATMENT PROVIDED YES NO OBSERVATION ONLY ADDRESS PHONE SIGNS/SYMPTOMS EXPERIENCED ADDRESS PHONE EMPLOYER PROTECTIVE MEASURES USED \_\_\_ EYES HANDS INHALATION OTHER **ENGINEERING CONTROLS** Cloth/Leather Gloves Dust Mask Work Clothes Closed System Safety Glasses Chemical Resistant Gloves 1/2 Face Respirator Coveralls **Enclosed Cab** Gogales Full Face Respirator Chemical Resistant Clothes Enc. Cab w/Air Purification Faceshield Other SCBA Chemical Resistant Boots Other Eve/Sun Glasses None None None Head Covering None Other \_ COMMENTS REPORT PREPARED BY (NAME/TITLE) DATE PREPARED REPORT REVIEWED/APPROVED BY (NAME/TITLE) DATE REVIEWED/APPROVED