

EPISODE WITNESS/INJURED/COMPLAINANT REPORT

REPORTABLE INVESTIGATION <input type="checkbox"/> YES # _____ <input type="checkbox"/> NO	OTHER I.D. NO.	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO _____ DAY _____ YR _____
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COMPLAINANT SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	WAS DOCTOR VISITED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	EXTENT OF INJURY/ILLNESS <input type="checkbox"/> Fatal <input type="checkbox"/> Symptoms <input type="checkbox"/> Serious <input type="checkbox"/> Exposed Only	ACTIVITY OF PERSON EXPOSED/INVOLVED <input type="checkbox"/> Mixer/Loader <input type="checkbox"/> Field Worker* <input type="checkbox"/> Other* <input type="checkbox"/> Applicator <input type="checkbox"/> Public* Explain _____
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WITNESS/INJURED/COMPLAINANT	NAME	AGE	SEX	WHS NO.	NO. OF WORKDAYS LOST	
	ADDRESS	CITY			ZIP CODE	PHONE
	<input type="checkbox"/> MEDICAL FACILITY NAME	<input type="checkbox"/> TREATMENT PROVIDED <input type="checkbox"/> OBSERVATION ONLY	<input type="checkbox"/> HOSPITALIZED <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE/TIME ADMITTED	DATE/TIME DISCHARGED
	PHYSICIAN	ADDRESS				PHONE
	<input type="checkbox"/> SIGNS/SYMPTOMS EXPERIENCED					
	<input type="checkbox"/> EMPLOYER	ADDRESS				PHONE

PROTECTIVE MEASURES USED EYES <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Faceshield <input type="checkbox"/> Eye/Sun Glasses <input type="checkbox"/> None	HANDS <input type="checkbox"/> Cloth/Leather Gloves <input type="checkbox"/> Chemical Resistant Gloves <input type="checkbox"/> Other _____ <input type="checkbox"/> None	INHALATION <input type="checkbox"/> Dust Mask <input type="checkbox"/> 1/2 Face Respirator <input type="checkbox"/> Full Face Respirator <input type="checkbox"/> SCBA <input type="checkbox"/> None	OTHER <input type="checkbox"/> Work Clothes <input type="checkbox"/> Coveralls _____ <input type="checkbox"/> Chemical Resistant Clothes <input type="checkbox"/> Chemical Resistant Boots <input type="checkbox"/> Head Covering <input type="checkbox"/> Other _____	ENGINEERING CONTROLS <input type="checkbox"/> Closed System <input type="checkbox"/> Enclosed Cab <input type="checkbox"/> Enclosed Cab w/Air Purification <input type="checkbox"/> Other _____ <input type="checkbox"/> None
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COMPLAINANT SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	WAS DOCTOR VISITED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	EXTENT OF INJURY/ILLNESS <input type="checkbox"/> Fatal <input type="checkbox"/> Symptoms <input type="checkbox"/> Serious <input type="checkbox"/> Exposed Only	ACTIVITY OF PERSON EXPOSED/INVOLVED <input type="checkbox"/> Mixer/Loader <input type="checkbox"/> Field Worker* <input type="checkbox"/> Other* <input type="checkbox"/> Applicator <input type="checkbox"/> Public* Explain _____
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	PHYSICIAN	ADDRESS				PHONE
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	<input type="checkbox"/> EMPLOYER	ADDRESS				PHONE

PROTECTIVE MEASURES USED EYES <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Faceshield <input type="checkbox"/> Eye/Sun Glasses <input type="checkbox"/> None	HANDS <input type="checkbox"/> Cloth/Leather Gloves <input type="checkbox"/> Chemical Resistant Gloves <input type="checkbox"/> Other _____ <input type="checkbox"/> None	INHALATION <input type="checkbox"/> Dust Mask <input type="checkbox"/> 1/2 Face Respirator <input type="checkbox"/> Full Face Respirator <input type="checkbox"/> SCBA <input type="checkbox"/> None	OTHER <input type="checkbox"/> Work Clothes <input type="checkbox"/> Coveralls _____ <input type="checkbox"/> Chemical Resistant Clothes <input type="checkbox"/> Chemical Resistant Boots <input type="checkbox"/> Head Covering <input type="checkbox"/> Other _____	ENGINEERING CONTROLS <input type="checkbox"/> Closed System <input type="checkbox"/> Enclosed Cab <input type="checkbox"/> Enc. Cab w/Air Purification <input type="checkbox"/> Other _____ <input type="checkbox"/> None
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COMMENTS

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE REVIEWED/APPROVED
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