



## Incident Exposure Record

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Incident Number \_\_\_\_\_ Incident Date \_\_\_\_\_

Officer in Charge \_\_\_\_\_

Location of Incident \_\_\_\_\_

Description of Incident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type of Exposure: Inhalation \_\_\_\_\_

Direct Contact \_\_\_\_\_

Ingestion \_\_\_\_\_

Materials Exposed To \_\_\_\_\_

\_\_\_\_\_

Type of Decontamination \_\_\_\_\_

Length of Exposure (time) \_\_\_\_\_

Symptoms (if any) \_\_\_\_\_

\_\_\_\_\_

Treatment at Scene \_\_\_\_\_

\_\_\_\_\_

Name of Medical Facility \_\_\_\_\_

Treatment Rendered \_\_\_\_\_

Protective Clothing and Equipment Used During Incident (list) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Firefighter/EMS Signature \_\_\_\_\_ Date \_\_\_\_\_

Chief's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Safety Officer's Analysis

What acts, failures to act and/or conditions contributed most directly to this accident? (Immediate Cause)

---

---

---

---

What are the basic or fundamental reasons for the existence of these acts and/or conditions? (Fundamental Cause)

---

---

---

---

What action has or will be taken to prevent recurrence? Place "X" by items completed.

---

---

---

---

---

---

---

---

---

---

Safety Officer's Comments \_\_\_\_\_

---

---

---

---

---

---

---

---

Safety Officer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_