

SUMNER FIRE DEPARTMENT  
EXPOSURE FORM

Exposed Member (Name) \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_

Address \_\_\_\_\_

Name of Patient \_\_\_\_\_

Suspected or Confirmed Disease \_\_\_\_\_

Transported to \_\_\_\_\_

Transported by \_\_\_\_\_

Date of Exposure \_\_\_\_\_

Time of Exposure \_\_\_\_\_

Incident # \_\_\_\_\_

WHAT WERE YOU EXPOSED TO:

- |                                      |                                  |                                 |                                |
|--------------------------------------|----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> BLOOD       | <input type="checkbox"/> TEARS   | <input type="checkbox"/> FECES  | <input type="checkbox"/> URINE |
| <input type="checkbox"/> SALIVA      | <input type="checkbox"/> VOMITUS | <input type="checkbox"/> SPUTUM | <input type="checkbox"/> SWEAT |
| <input type="checkbox"/> OTHER _____ |                                  |                                 |                                |

Hazardous Materials Involved (Names) \_\_\_\_\_

\_\_\_\_\_

What part(s) of your body became exposed \_\_\_\_\_

\_\_\_\_\_

Explain how exposure occurred \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you seek Medical Attention:  YES  NO

Where \_\_\_\_\_

Officer Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Contact Chief \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Member Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_