

Littleton Fire Rescue – Personal Exposure Recording System (Not to be used for Medical Exposures)

Name _____ Incident Address _____
 Incident Date _____ Alarm Time _____ Incident Number _____

I. Incident or Exposure Type (check one)

- Residential Fire Industrial Fire Vehicle Fire/Collision Commercial Fire
 Trash/Dumpster Haz Mat Incident
 Explosion Spill Other (briefly describe)
 Detail on Type of Structure (single family, duplex, etc.) _____

II. Length of Exposure by Fire Stage / Activity

Fire Stage:	Hours Exposed (write in)	PPE used?
Incipient		
Free Burning		
Smoldering		
Non-Fire Incident		

Activity:	Hours Exposed?	PPE used?
Extinguishment		
Entry/Ventilation		
Rescue/Extrication		
Light Overhaul		
Heavy Overhaul		
EMS		
Investigation		

III. Smoke/Chemical/Medical Exposure

Smoke Conditions: Light Heavy None
 Smoke Color(s): _____

Chemical(s) Present	Vapor/Gases	Dust	Light/Heaty Mist	Combust Prod	Solid/Powder	Comments
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Route of Exposure: Inhaled Ingested Skin Contact Eye Contact

IV. Symptoms

At Incident	Symptoms	After Incident
	Eyes Burn	
	Cough	
	Cough Blood/Nose Bleed	
	Nose/Lung Irritation	
	Nausea/Queasiness	
	Dizzy	

At Incident	Symptoms	After Incident
	Ears Ringing	
	Headache	
	Skin Irritation/Rash	
	Unconscious	
	Other:	

V. Medical Diagnosis – Did you receive any medical assessment or treatment at the scene rehab unit? Yes No

Did you receive medical evaluation or treatment from a medical professional after exposure? Yes No

Name of Doctor/Treatment Facility _____

VI. Protective Equipment / Decontamination

Were you provided with protective equipment for this incident other than required by OSHA? (SCBA is Required) Yes
 No

Chemical Protective Suit Overhaul Mask Other: _____

Were decontamination procedures followed after the exposure? Yes No

Describe:

VII. Co-Workers at Time of Exposure - Please list names of other firefighters working close to you at time of exposure:

VIII. Additional Information - Employees must forward a copy to the Operations Division Chief and keep a copy for their personal files.