

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.