

STATE OF CALIFORNIA
PESTICIDE EPISODE INVESTIGATION REPORT
 PR-ENF-127 (REV. 8/07) PAGE 1 OF 1

A. GENERAL INFORMATION

RECEIVED BY _____	RECEIVED FROM _____	REPRESENTING _____	DATE/TIME RECEIVED <input type="checkbox"/> AM <input type="checkbox"/> PM	PERSON NOTIFIED _____	DATE _____
TYPE OF EPISODE <input type="checkbox"/> HUMAN EFFECTS # _____ <input type="checkbox"/> PROPERTY LOSS \$ _____		ENVIRONMENTAL EFFECTS <input type="checkbox"/> ENVIRONMENTAL EFFECTS <input type="checkbox"/> OTHER _____	PRIORITY INVESTIGATION <input type="checkbox"/> YES # _____ <input type="checkbox"/> NO		
OTHER I.D. NO. _____	COUNTY OF OCCURRENCE _____	DATE OF OCCURRENCE MO _____ DAY _____ YR _____	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	DFA _____	_____
EPISODE LOCATION _____				DFG _____	_____
				DPH _____	_____
				DIR _____	_____
				EPA _____	_____
				CAC _____	_____
				OTHER _____	_____

B. INJURED/COMPLAINANT INFORMATION

COMPLAINT SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	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"/> Serious	<input type="checkbox"/> Symptoms <input type="checkbox"/> Exposed Only	ACTIVITY OF PERSON EXPOSED/INVOLVED <input type="checkbox"/> Mixer/Loader <input type="checkbox"/> Applicator	<input type="checkbox"/> Field worker* <input type="checkbox"/> Public*	<input type="checkbox"/> Other* *Explain _____
NAME _____		AGE _____	SEX _____	WHS NUMBER _____	WORKDAYS LOST _____	
ADDRESS (Number and Street, City, State, ZIP Code) _____					PHONE _____	
MEDICAL FACILITY NAME _____	<input type="checkbox"/> TREATMENT PROVIDED <input type="checkbox"/> OBSERVATION ONLY	HOSPITALIZED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE/TIME ADMITTED _____	DATE/TIME DISCHARGED _____		
PHYSICIAN _____	ADDRESS (Number and Street, City, State, ZIP Code) _____				PHONE _____	
SIGNS/SYMPTOMS EXPERIENCED _____						
EMPLOYER _____			ADDRESS (Number and Street, City, State, ZIP Code) _____			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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C. ENVIRONMENTAL OR PROPERTY DAMAGE

DESCRIPTION OF DAMAGE _____	AMOUNT/VALUE _____
OWNER _____	ADDRESS (Number and Street, City, State, ZIP Code) _____
	PHONE _____

D. ALLEGED RESPONDENT(S)

PCA DEALER PILOT GROWER AGENCY OTHER

NAME _____	PHONE _____	LICENSE/PERMIT NUMBER _____	RECOMMENDATION MADE <input type="checkbox"/> YES # _____ <input type="checkbox"/> NO
ADDRESS (Number and Street) _____		EMPLOYER'S NAME _____	PHONE _____
City, State, ZIP Code _____		EMPLOYER'S ADDRESS (Number and Street) _____	
*EXPLAIN _____		City, State, ZIP Code _____	

PESTICIDE NAME/MANUFACTURER	EPA REGISTRATION NUMBER	CATEGORY	DOSE/DILUTION/VOLUME	TREATMENT DATE	COMMODITY/SITE TREATED

EQUIPMENT TYPE/MAKE/MODEL/DESCRIPTION _____

SUMMARIZE THE EPISODE INCLUDING A DETAILED DESCRIPTION OF EVIDENCE TAKEN (Use Pesticide Episode Investigation Supplemental Report form PR-ENF-127A if additional space is needed)

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