

PESTICIDE EPISODE INVESTIGATION NON-OCCUPATIONAL EXPOSURE SUPPLEMENT

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NAME OF INTERVIEWEE	ADDRESS	CITY	ZIP CODE
TELEPHONE NUMBER ()	COUNTY	DATE OF EXPOSURE	TIME OCCURRED AM PM
EXPOSURE SITE <input type="checkbox"/> HOUSE <input type="checkbox"/> APT <input type="checkbox"/> SCHOOL <input type="checkbox"/> VEHICLE TYPE _____ <input type="checkbox"/> RETAIL <input type="checkbox"/> OPEN AREA <input type="checkbox"/> OTHER _____		NUMBER EXPOSED OUTDOORS _____	IS EXPOSURE ONGOING? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID ANYONE SEE A DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOW MANY SAW A DOCTOR?	NAME OF DOCTOR/MEDICAL FACILITY
ADDRESS OF DOCTOR/MEDICAL FACILITY		CITY	TELEPHONE NUMBER ()
DATE(S) PERSONS SAW A DOCTOR	WAS ANYONE HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", HOW MANY PERSONS?	IF "YES", HOW LONG (DAYS)?

LOCATION OF EXPOSURE - BE SPECIFIC. USE PAGE 2, IF NEEDED ATTACH A MAP IF DESIRED

DESCRIBE HOW EXPOSURE OCCURRED. DESCRIBE LOCATION, ACTIVITIES, WHAT HAPPENED, WHAT WAS SEEN, HEARD, SMELLED, TASTED AND FELT. USE PAGE 2, IF NEEDED.

NAME OF PERSONS EXPOSED IN BUILDING (CONTINUE LIST ON PAGE 2, IF NECESSARY)	GENDER (M/F)	DATE OF BIRTH (OR AGE)	SYMPTOMS EXPERIENCED	HAVE SYMPTOMS RESOLVED?
(SPACE 1 IS FOR PERSON BEING INTERVIEWED)			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
1			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
2			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
3			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
4			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
5			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
6			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
7			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
8			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
PESTICIDE ALLEGEDLY INVOLVED		REGISTRATION NUMBER FROM LABEL	COMMODITY/SITE TREATED	
PERSON/FIRM/ALLEGEDLY RESPONSIBLE		OWNER OR OPERATOR OF PROPERTY TREATED		
INVESTIGATOR'S NAME (PRINT)	INVESTIGATOR'S SIGNATURE		TITLE	DATE

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NAME OF PERSONS EXPOSED IN BUILDING (CONTINUE LIST ON PAGE 2, IF NECESSARY)	GENDER (M/F)	DATE OF BIRTH (OR AGE)	SYMPTOMS EXPERIENCED	HAVE SYMPTOMS RESOLVED?
9			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
10			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
11			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
12			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
13			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
14			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
15			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO

CONTINUATION OF REMARKS: (EXPOSURE LOCATION, HOW EXPOSURE OCCURRED)

INVESTIGATOR'S NARRATIVE

PLOT MAP
