

Health & Safety

Report

Worker Health and Safety Branch

HS-1781

**PHYSICIAN REPORTING OF PESTICIDE ILLNESSES,
PART I. MASS MAILING AND
PERSONAL NOTIFICATION
1994-1996**

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M. Kathy Orr, Environmental Research Scientist
Louise Mehler, Associate Toxicologist

Worker Health and Safety Branch
Department of Pesticide Regulation
California Environmental Protection Agency

Executive Summary

As a result of legislation in 1971 and amended in 1977, California physicians are required to report by telephone to the local health department all cases of illness or injury that may have been a result of exposure to pesticides. Section 105200 of the California Health and Safety Code requires physicians to report to the county health officer any patients whose condition they know or have reason to believe derived from exposure to pesticides. When this requirement is met, the county health department informs the county agricultural commissioner and also completes a Pesticide Illness Report (PIR), copies of which are distributed to the State Office of Environmental Health Hazard Assessment (OEHHA), California Department of Industrial Relations (DIR) and Department of Pesticide Regulation (DPR).

DPR initiated an effort in 1994 to improve physician familiarity and compliance with the reporting requirement. This document summarizes efforts undertaken to enhance the familiarity of California physicians with the reporting requirements. Identifying cases that might escape detection otherwise, direct physician reporting allows DPR to investigate cases promptly, assuring access to the exposed population(s), with event details accurately recalled. Approximately half of all direct physician reports are received within two weeks of the incident and about 90 percent within the month following exposure. In reality, DPR receives reports of pesticide-related illnesses through a variety of reporting mechanisms. About three-quarters of the total cases are identified through workers' compensation records and are more than a month old by the time they are obtained. Staff review workers' compensation cases for evidence of pesticide involvement.

County agricultural commissioners investigate all cases identified as potentially related to pesticide exposure. The data is subsequently evaluated and compiled into DPR's Pesticide Illness Surveillance Program (PISP) database. Automated in 1982, this database provides an important source of information for developing both state and national regulatory initiatives. Pesticide exposure circumstances that result in illness are evaluated regularly by staff. Staff then use the information to assess the effectiveness of the DPR pesticide safety regulatory programs.

In 1994, DPR and DIR mailed to all licensed California physicians summaries of the reporting requirements for pesticide-related illnesses. Then in 1995 and 1996 the names of physicians from pesticide-related worker's compensation records were recorded. When DPR received no corresponding PIR through the local health officer, each physician received a letter outlining the reporting requirement in addition to referencing the case or cases located through workers' compensation. A total of 1,371 letters were sent to 996 different doctors by the end of 1996. During this same period, OEHHA, which has statutory responsibility for medical training, conducted outreach sessions in Orange, Riverside, and Stanislaus Counties. These counties were targeted because they had not only poor records of direct reporting but also substantial numbers of cases identified through workers' compensation.

The results of this effort were reflected in an increased physician reporting from a low of 12 to 13 percent in 1992 and 1993 to 30 percent of cases in 1997. In 1997, DPR discontinued this activity as it took considerable staff time. A pilot project was undertaken with the California Poison Control System to assist consulting physicians with the reporting requirement.

Introduction

Pesticide-related illnesses have been tracked within the state of California for nearly 50 years. The California Department of Pesticide Regulation (DPR) maintains a surveillance program that records human health effects of pesticide exposure. Information on adverse effects from pesticide products, including active ingredients, inert ingredients, impurities, or breakdown products are documented by the Pesticide Illness Surveillance Program (PISP). This program maintains a database, which is utilized for evaluating the circumstances of pesticide exposures resulting in illness. This data is reviewed regularly by staff who evaluate the effectiveness of the DPR pesticide safety programs and recommend changes when appropriate.

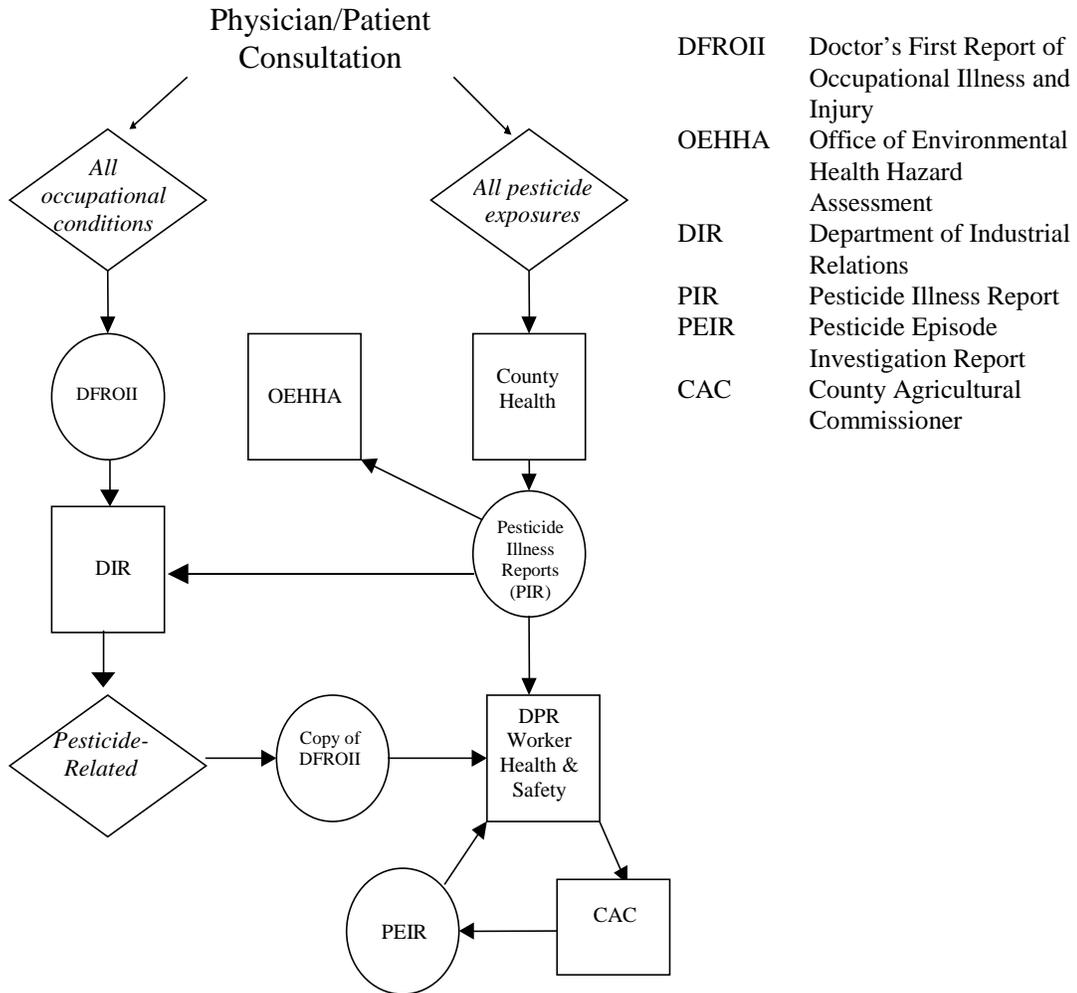
California physicians are required by law to report any cases which appear to be related to pesticide exposure. Physician reporting of pesticide-related illness and injury has been mandatory in California since 1971. Section 105200 of the Health and Safety Code states “Any physician and surgeon who knows, or has reasonable cause to believe, that a patient is suffering from pesticide poisoning or any disease or condition caused by a pesticide shall promptly report such fact to the local health officer by telephone within 24 hours and by a copy of the report required pursuant to subdivision (a) of section 6409 of the Labor Code within seven days, except that the information which is available to the physician and surgeon is all that is required to be reported as long as reasonable efforts are made to obtain such information.”

Initially, the reports are transmitted to the local health officer, who generates a Pesticide Illness Report (PIR). (The PIR reporting form [OEH-PETS 003, Rev. 6/95] is included at the end of this document.) The health officer transmits the report to the county agricultural commissioner; copies are also distributed to the Office of Environmental Health Hazard Assessment (OEHHA), the California Department of Industrial Relations (DIR), and DPR. DIR has enforcement authority for the reporting requirement. OEHHA is charged with developing and implementing a medical education program for health care professionals, including physicians. This educational program focuses on the recognition, diagnosis, treatment and reporting of pesticide poisonings. OEHHA also has joint and mutual responsibility with the DPR to develop regulations to protect workers exposed to agriculture pesticides.

To supplement physician reporting, DPR staff review workers' compensation cases to determine if pesticides have been involved. In fact, most of the cases are currently identified through workers' compensation rather than direct physician reporting. The incentive to file the workers' compensation reports is considerably higher than pesticide illness reports because a physician's payment for services is dependent on this submission. The physician-generated form entitled “Doctor's First Report of Occupational Illness and Injury” (DFROII) is provided to DIR via those who pay (insurers, employers) worker's compensation claims, assuring physician payment for services. (A copy of the DFROII (Form 5021, rev. 4) is provided at the end of this report.) A flowchart outlining the DPR's receipt of pesticide related illnesses by either PIR or DFROII is provided in Figure 1.

Figure 1

PESTICIDE ILLNESS SURVEILLANCE FLOWCHART



County agricultural commissioners (CAC) investigate all cases that are identified as possibly related to pesticide exposure. Subsequently, DPR staff evaluates the data and enters it into a database. DPR maintains the PISP database in order to evaluate circumstances of pesticide exposures that result in illness. Staff analyzes the data collected to evaluate the effectiveness of pesticide safety regulatory programs and determine the need for change. OEHHA also responds to requests for assistance and information, and provides physicians and other medical professionals with guidelines for medical supervision including cholinesterase monitoring of agricultural pest control workers. When physicians properly notify the local health officers of pesticide illnesses, DPR and the CAC receive copies of PIRs promptly, typically within two weeks of a pesticide exposure. Since the DFROIIs are not provided to DPR directly, this delays investigations. Approximately three-quarters of the cases identified through workers' compensation records are greater than a month old by the time they are located.

This report documents the activities undertaken by DPR, OEHHA and DIR in an attempt to increase California physicians' familiarity and compliance with the reporting requirement.

Materials and Methods

In 1994, DPR, DIR and OEHHA began a joint project to improve direct physician reporting of pesticide-related exposures. Initially, a notice was placed in the Medical Board Action Report (a physician-read journal) describing the reporting requirement and requesting cooperation. Late in the year, DPR in cooperation with DIR mailed single-page summaries of the relevant regulations to all physicians (more than 70,000) with active California licenses. Additionally, a list of the local health officers' telephone numbers was provided for report transmission. In 1994, OEHHA conducted outreach training in Stanislaus, Orange, and Riverside Counties stressing recognition of pesticide illnesses and the importance of physician reporting. These counties were selected because they had poor records of reporting in addition to substantial numbers of cases identified through workers' compensation.

During 1995 and 1996, DPR sent individual letters to physicians when pesticide illness reports were not received for cases identified through alternative sources. The DPR PISP database was modified to collect the identity of the physician and the consultation date for those cases identified through workers' compensation records. If no corresponding PIR had been received through the local health officer, a notification letter was generated referencing the specific consultation and providing the physician with the telephone number of the health officer for reporting such cases. The contents of the notification letter included the definition of a pesticide emphasizing the inclusion of antimicrobials. When subsequent unreported cases by the same physician were identified by DPR, a more strongly worded letter was generated and sent by certified mail to those physicians. Several certified letters reached physicians whose initial notification had not been delivered because the post office forwards certified mail longer after a move than regular mail. The names of a few physicians who repeatedly ignored requests to comply were referred to DIR for possible enforcement action.

Other outreach efforts followed. Similar discussions were included in letters sent to medical directors of poison control centers. Local health officers received reminder letters and the chief of the Worker Health and Safety Branch explained the program and reporting requirements to the California Conference of Local Health Officers. OEHHA incorporated a sub-heading "including sanitizers and disinfectants" into the revised PIR form of June of 1995, to remind physicians that these chemicals are pesticides.

Results

Reporting prior to notification

Prior to 1995, the fraction of cases received by direct physician reporting (PIRs) had been declining. From 1983 through 1987, DPR identified by PIR thirty-two percent of the cases investigated. In 1988 and 1989, this dropped to twenty percent, then to sixteen percent in 1990.

From 1991 through 1993, DPR received PIRs for only twelve or thirteen percent of the cases (excluding the 443 PIRs among the 459 cases related to the metam-sodium spill at Cantara in 1991). This is illustrated in Figure 2. The actual values are reported in Table 1.

Figure 2

**California Pesticide Illness Surveillance Program:
Cases Investigated 1983 - 1997**



Table 1
Distribution of Pesticide Illness Reporting from 1983 - 1997

YEAR	ILLNESS REPORTING MECHANISM						TOTAL CASES
	PIR ¹	%	DFROII ²	%	OTHER	%	
1983	684	26.96	1514	59.68	339	13.36	2537
1984	702	28.52	1488	60.46	271	11.01	2461
1985	786	31.45	1453	58.14	260	10.4	2499
1986	901	43.05	791	37.79	401	19.16	2093
1987	846	29.2	1681	58.03	370	12.77	2897
1988	619	19.69	2276	72.39	249	7.92	3144
1989	582	20.6	2113	74.8	130	4.6	2825
1990	477	15.93	2201	73.49	317	10.58	2995
1991	338	12.33	2076	75.74	327	8.1	2741
1992	348	12.92	1947	72.27	399	14.81	2694
1993	252	11.94	1497	70.91	362	17.15	2111
1994	310	15.54	1422	71.28	263	13.18	1995
1995	529	22.03	1405	58.52	467	19.45	2401
1996	566	25.39	1359	60.97	304	13.64	2229
1997	533	29.51	1030	57.03	243	13.46	1806

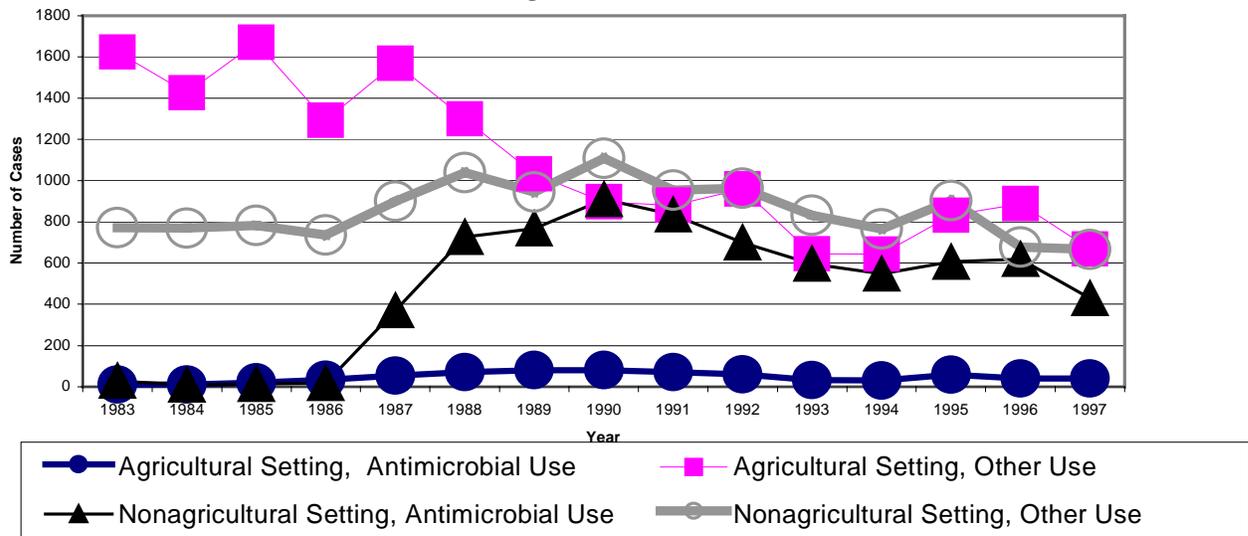
¹ PIR – Pesticide Illness Report

² DFROII – Doctor’s First Report of Occupational Illness and Injury

The decline in reporting by PIR occurred in the context of changes in the types of cases that occurred and the locations of their occurrence. From 1983 through 1989, DPR identified over 1,000 agricultural cases each year (range = 1,113 - 1,691). Since then, fewer than 1000 agricultural cases have been identified each year, with only 678 in 1993 and 674 in 1994. The number of non-agricultural cases identified annually averaged 942 until DPR began searching out antimicrobial cases in 1987. The number of non-agricultural cases, excluding antimicrobial cases, average 896 through 1992. Since then numbers have declined in all categories, with identification of 832 non-agricultural, non-antimicrobial cases in 1993 and 766 in 1994. Starting in 1987, receipt of both agricultural and non agricultural antimicrobial cases increased rapidly reaching 989 and 907 cases in 1990 and 1991, subsequently decreasing to 783, 744 and 576 in 1992, 1993 and 1994, respectively¹. These trends are illustrated in Figure 3.

¹ This data excludes the 459 cases generated from a metam-sodium spill that took place in July of 1991. A derailed train spilled one carload of about 19,000 gallons of metam sodium into the Sacramento River.

Figure 3
**California Pesticide Surveillance Program
 Incident Setting and Intended Pesticide Use**



Apparently, very few doctors recognize antimicrobials as pesticides that are to be reported. In twelve years, DPR received only 160 PIRs on antimicrobial cases, while identifying 6,275 of them through other sources. Even excluding antimicrobial cases, agricultural cases are more likely to be reported by PIR than non-agricultural cases. Between one-quarter and one-half of the agricultural cases investigated each year have been identified by PIR. These percentages show a broad peak, increasing from 25% in 1983 to 54% in 1986, gradually decreasing to 25% again by 1992. Only 10 to 24 percent of the non-agricultural, non-antimicrobial cases were reported by PIR; and the percentage has been declining, with fewer than 15 percent reported by PIR since 1988.

The San Joaquin Valley has been the major source of agricultural cases as well as of PIRs. Fresno, Kern and Tulare Counties regularly reported (by all mechanisms) over a hundred agricultural cases a year each from 1983 through 1992. Kings, Madera, Merced, San Joaquin and Stanislaus report lower but still noticeable numbers. Outside the San Joaquin Valley, only Monterey County regularly reports such large numbers of agricultural cases.

Early electronic records (1983 and 1984) show Kern and Tulare Counties as the only ones reporting a substantial fraction of their cases (45 to 47 percent) by PIR. Only a small number of non-agricultural cases came from Kern and Tulare, but they were equally likely to be reported by PIR. In 1985, Fresno County physicians began reporting at levels comparable to those in Kern and Tulare counties. Reporting in Fresno as well as Kern and Tulare counties remained high through 1989, sometimes exceeding half of all cases identified in those counties. In the 1990's, compliance decreased; though they remain among the counties with the largest percentage of cases identified by PIR. Additionally, total numbers of cases identified in the three counties have

declined substantially since 1992. By 1995, fewer than 100 cases each came from Kern and Tulare counties, including non-agricultural and antimicrobial cases as well as agricultural.

Reporting During the Notification Effort

Larger numbers and higher percentages of cases were reported by PIR during 1995 and 1996. Antimicrobial case reporting increased from negligible levels to nearly ten percent of the total in those two years. In 1995, 64 of 678 antimicrobial cases were reported by PIR; and in 1996, 44 of 501 were. Of those cases involving pesticides other than antimicrobials, in 1995, 465 of 1723 (27%) were reported by PIR; 522 of 1702 (31%) were reported by PIR in 1996. Reporting in 1996 was augmented by a large drift episode that accounted for 151 PIRs among 243 cases. Excluding that episode from both totals leaves 371 of 1459 cases (25%) reported by PIR.

The improvement in reporting represented a return to levels recorded during the early 1980's. In the San Joaquin Valley, nearly half of all non-antimicrobial cases investigated were identified by PIR in 1995 and 1996, along with over 20% of the antimicrobial cases. The rural and mixed economy counties of Northern California reported 38% of their non-antimicrobial cases by PIR. The urban counties of the central coast reported 17% of their non-antimicrobial cases by PIR in 1995, improving to 23% in 1996. The southernmost counties received 13% by PIR in 1995 and 17% in 1996.

Two of the three counties selected for outreach training lie in the southern part of the state. Orange County averaged three PIRs per year from 1983 through 1994, while investigating an average of 105 cases per year. In 1995, Orange County reported five cases via PIR among 98 cases investigated, with 12 PIRs among 74 cases in 1996. Riverside County, investigating an average of 80 cases per year, reported its first case via PIR in 1988, and at the end of 1994 had reported seven cases by PIR. Riverside County reported six cases via PIR of 93 total cases in 1995 and 12 of 56 in 1996.

Stanislaus County is at the northern end of the San Joaquin Valley, and from 1983 through 1987 reported 146 of its 297 cases by PIR. During the following seven years, poorly reported antimicrobial cases came to compose a substantial fraction of the caseload. Even among cases involving other sorts of pesticides, however, just 70 of 316 were reported by PIR. In 1995, Stanislaus County reported 14 cases by PIR among 61 total cases, including 19 antimicrobial cases, none of which generated a PIR. The 62 cases investigated in 1996 included 31 reported by PIR, including two of the eight antimicrobial cases.

Discussion

Oregon and Washington State both have pesticide illness reporting systems. Much like California, they rely on multiple sources for reporting. In 1994, 53 pesticide-related incident reports were investigated by the Oregon Pesticide Analytical and Response Center (PARC), within the Oregon Health Division (OHD). [1] PARC is mandated by statute to collect and analyze incident information regarding incidents of pesticide exposure and to coordinate investigations. This center does not have enforcement authority. OHD and Oregon Occupational Safety and Health Division (OR-OSHA) handle investigations and enforcement actions. There were 101 individuals reportedly exposed to pesticides resulting from these incidents. Workers compensation data claims reflect that less than 20 percent of cases are being reported and investigated. The sources of these incidents are provided in Table 2.

Table 2
Summary of Pesticide Incident Source for Oregon

Incident Report Source (PARC¹ Cases –1994)	
Direct from Citizen	22
Department of Agriculture	6
County Health Departments	6
Health Care Providers	6
Oregon Poison Center	5
Other State Agencies	5
Employer	3
Total²	53

¹ PARC - Pesticide Analytical and Response Center Oregon

² 101 individuals were involved in the 53 incidents

The state of Washington produces an annual report, which tracks reviews and reports pesticide incidents within the state. [2] This report is directed by statute (RCW 70:104.090) and input is provided by multiple agencies including the Washington State Departments of Agriculture (WSDA), Health (DOH), and Labor and Industries (L&I). In addition, the state is directed to identify inadequacies in pesticide regulations that result in insufficient protection of human health. WSDA received 251 pesticide incident reports in 1996. DOH investigated 402 incidents involving 504 persons. Two hundred and twenty two pesticide-related claims were received through L&I worker compensation claims. In addition to these three sources, the state of Washington also maintains a poison control center, which received 3,092 pesticide-related calls in 1996. One hundred and ninety five of these were referred to DOH for investigation. Cases are investigated only when there are clinical signs and symptoms indicative of pesticide exposure.

Table 3

Pesticide Incident Reporting and Tracking Washington State 1996 Data	
WSDA ¹	251
DOH ²	402
L&I ³	222
Total Investigated	875

¹ WSDA - Washington State Department of Agriculture

² DOH – Department of Health

³ L&I - Labor and Industries

In 1996, a San Joaquin Valley physician commented on mandatory reporting.[3] He expressed three problems: (1) there is lack of clarity regarding what a pesticide is; (2) the process has too many parts including three reports and telephone calls; and (3) multiple agencies receive copies of this report. He also expressed criticism of the PIR report form itself, stating that it asks for information that neither the patient nor the reporting physician can answer. One of his biggest criticisms of the system is the lack of feedback to the physician regarding the outcome of the investigation.

DPR undertook this project to familiarize physicians with the reporting requirement and a definition of pesticide. To satisfy the reporting requirement, the physician need only contact the local health officer by telephone within 24 hours of seeing a patient for suspected pesticide poisoning. The local health department fills out the paper work and sends it to the appropriate agencies. Multiple agencies do receive copies of the report, but the physician has no involvement in that part of the process. Physicians in the California Department of Health Services (now OEHHA) originally designed the PIR. It was a very simple form with only a items to fill out. The PIR has become more complex in recent years; many of the boxes request information that is collected during the incident investigation. DPR plans to work with OEHHA to simplify the PIR form. In addition, DPR is studying the feasibility of sending a copy of the annual summary report to each physician who reports a pesticide-related illness.

Over the years, physician reporting of pesticide-related incidents has been a very valuable tool in learning about pesticide-related exposures. Direct physician reporting allows investigators earlier contact with the exposed people which should result in a more accurate account of what happened. The pesticide worker safety regulatory program has been strengthened as a direct result of pesticide illness surveillance.

Conclusions

Overall, this effort increased physician reporting to 30 percent of cases in 1997 from a low of 12 to 13 percent in 1992 and 1993. Generating notification letters took about four hours a week. In addition, responding to physicians' calls often occupied several additional hours each week. In 1995, DPR sent 635 letters to 518 physicians regarding 676 patients. In 1996, 736 letters were sent to 599 physicians regarding 769 patients. This averages 12 to 14 letters generated per week.

Because of the staff resources involved, DPR sought alternative methods to increase physician reporting. In 1996, DPR initiated a pilot project by contracting with the poison control center, serving the San Joaquin Valley. During this year, this poison control center provided the to the physician the option of reporting pesticide cases on the behalf of physicians. Although there were not large numbers of reports received through this avenue, they were often received within a day or two of the incidents.

Published notices and mass mailings appear to have been effective. Individual correspondence with physicians produced visible results. Staff recommends continuing attempts to improve reporting by investigating ways to involve support staff at hospitals, laboratories, poison control centers, and other medical institutions.

References

1. *Oregon Pesticide Analytical and Response Center 1995 Annual Report*, . 1995, State of Oregon.
2. *1996 Annual Report: Pesticide Incident Reporting and Tracking Review Panel*, . 1996, Washington State Department of Health. Office of Toxic Substances.
3. Lessenger, J.E., *The California Pesticide Program: comments from the front lines.* Journal of Agromedicine, 1996. v.3(4) P. 57-58.

Appendix A

Acronym Index

Acronym	Name
CAC	County Agricultural Commissioner
DFROII	Doctor’s First Report of Occupational Illness and Injury
DIR	Department of Industrial Relations
DOH	Department of Health (Washington state)
DPR	Department of Pesticide Regulation
L&I	Labor and Industries (Washington state)
OEHHA	Office of Environmental Health Hazard Assessment
OHD	Oregon Health Division
PARC	Oregon Pesticide Analytical and Response Center
PIR	Pesticide Illness Report
PISP	Pesticide Illness Surveillance Program
WSDA	Washington State Departments of Agriculture

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

PLEASE DO NOT

1. INSURER NAME AND ADDRESS				
2. EMPLOYER NAME				Case No. _____
3. Address	No. and Street	City	Zip	Industry _____
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothing)				County _____
5. PATIENT NAME (first name, middle initial, last name)		6. Sex [] Male [] Female	7. Date of birth Mo. Day Yr.	Age _____
8. Address	No. and Street	City	Zip	9. Telephone number () _____ Hazard _____
10. Occupation (Specific job title)			11. Social Security Number - - -	Disease _____
12. Injured at:	No. and Street	City	County	Hospitalization _____
13. Date and hour of injury	Mo. Day Yr.	Hour _____ a.m. _____ p.m.	14. Date last worked	Mo. Day Yr. Occupation _____
15. Date and hour of first	Mo. Day Yr.	Hour _____ a.m. _____ p.m.	16. Have you (or your office) treated patient? [] Yes [] No Return Date/Code _____	

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability of failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under California Labor Code.

17. DESCRIBE HOW THE ACCIDENT HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)

19. OBJECTIVE COMPLAINTS (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if none pending.)

20. DIAGNOSIS (If occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds [] Yes [] No
ICD-9 Code _ _ . _ _

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? [] Yes [] No If "no", please explain

22. Is there any current condition that will impede or delay a patients recovery? [] Yes [] No If "no", please explain

23. TREATMENT RENDERED (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? [] Yes [] No

If "no", date when patient can return Regular work ___/___/___
Modified work ___/___/___

Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor's Name and Degree (please type) _____ IRS Number _____

Address _____ Telephone Number () _____

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purposes of obtaining or denying workers' compensation benefits or payments is guilty of a

PESTICIDE ILLNESS REPORT
(For illnesses caused by pesticides--including sanitizers and disinfectants)

PATIENT:

Name: Age: Sex: M F
Address: City: County:
Phone No.: Social Security Number:
Occupation: Language: English Spanish Other

PHYSICIAN FILING REPORT:

Physician's name:
Physician's address:

Injury:

At Address: City: County:
Was Injury: At Home At Work - agriculture At Work - nonagriculture Other exposure
If at work: a) Employer's name
Employer's address:

b) Manager or Supervisor:

Date of exposure: Time of exposure:
Date of illness: Date of death:
Is there reason to believe others were exposed? No Yes

PATIENT'S DESCRIPTION OF EXPOSURE:

Activity at time of exposure:
 Applying Pesticides Manufacturing pesticides Mixing pesticides Entering pesticide areas
 Disposing of pesticides or their containers Eating contaminated food
 Other exposure (explain):

Name of pesticide(s): Ingredient(s) of pesticide(s):

Primary route of exposure: Oral Dermal Eye Inhalation Unknown

PHYSICIAN'S DESCRIPTION OF EXPOSURE:

Date first seen: Time first seen:
Major signs, symptoms, adverse reactions:
Hospitalized? No Yes If Yes, hospital name: City:
Emergency room only? No Yes
Physician's office only? No Yes
Diagnostic studies ordered? No Yes If yes, which studies?
Diagnosis:
Treatment:

Brief description of incident (if female, indicate if pregnant):

AGENCY COMPLETING FORM:

Agency/County: By whom:
Address:
Phone no.