

HAZARDOUS MATERIAL EXPOSURE FORM

Name:

Department:

Job Title:

Gender: Male Female

Date/Time of Incident:

To whom was the incident first reported?

Describe location of incident: (i.e. Building, Room number)

Names and contact details of any witnesses:

Describe how the incident occurred and any contributing factors:

**Were controls in place to reduce Hazardous Material exposure?
(I.e. ventilation, procedures, PPE, etc.)**

What was the extent of the contaminated area?

A. Exposure Route

Ingestion Inhalation Injection Contact/Absorption

B. Part(s) of body exposed (Circle Left (L) and/or Right (R))

Arm L/R back torso front torso eye L/R face foot L/R
 Respiratory system head leg L/R mouth neck hand L/R
 Other: _____

C. Was Medical Treatment required?

Yes No (If Yes) by whom and what
type _____

D. Hazardous material(s) possibly exposed to (list material):

E. Have you ever had any previous exposure to the above-mentioned material(s) at another employer?

Yes

(If Yes) Name, Date the employer and the job _____

No

F. Have you ever had an exposure related medical exam for the above-mentioned materials?

Yes

(If yes) when was the most recent? _____

No

G. Personal Protective Equipment used (Check all that apply)

Glove type: latex Neoprene Nitrile Other:

Protective Clothing: Coverall and/or chemical suit (What Type?) _____

Footwear (What Type?) _____

Eye/face/head protection (What Type?) _____

Completed by:

Printed Name:

Signature:

Date:

Reviewed by Supervisor

Printed Name:

Signature:

Date:

Review by GDC Fire and Life Safety Offices:

Printed Name:

Signature:

Date:

Comments:

*** Attach additional sheets for more information if needed. Include sketches and photographs if available.**