



City of Philadelphia

Risk Management Division, Safety and Loss Prevention unit

Hazardous Material Exposure Incident Report

Issued: 1/17/08

Note: Please complete this form entirely and accurately. If you have any questions please contact the Safety and Loss Prevention Unit of Risk Management at 215-683-1704.

Personal Details	
Last Name:	First Name:
Payroll/Badge ID#:	Phone (w):
Department:	Unit/Division:
Job Title:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Incident Details	
Date incident occurred: / /	Time of incident: am/pm
Date incident reported: / /	To whom was the incident first reported:
Describe location of incident as follows: building name, room number, street address or fieldwork site	
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? (ex. ventilation, procedures, PPE, etc.)	
What was the extent of the contaminated area?	
Attach additional sheets for more information if needed; include sketches and photographs.	

Exposure details					
A. Exposure Route					
<input type="checkbox"/> Ingestion	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Injection	<input type="checkbox"/> Contact/Absorption		
B. Part(s) of body exposed (Circle Left (L) and/or Right (R))					
<input type="checkbox"/> arm L/R	<input type="checkbox"/> back torso	<input type="checkbox"/> front torso	<input type="checkbox"/> eye L/R	<input type="checkbox"/> face	<input type="checkbox"/> foot L/R
<input type="checkbox"/> respiratory system	<input type="checkbox"/> head	<input type="checkbox"/> leg L/R	<input type="checkbox"/> mouth	<input type="checkbox"/> neck	<input type="checkbox"/> hand L/R
<input type="checkbox"/> Other: _____					
C. Was Medical Treatment required?					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If Yes) By whom and what type _____			
D. Has a <u>COPA II</u> (employee injury report) been completed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
E. Hazardous material(s) possibly exposed to (list material):					
F. Have you ever had any previous exposure to the above-mentioned material(s) at another employer?					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If Yes) Name the employer and the job _____			
G. Have you ever had an exposure related medical exam for the above-mentioned materials?					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If Yes) When was the most recent? _____			
H. Personal Protective Equipment used (Check all that apply)					
Glove type:	<input type="checkbox"/> latex	<input type="checkbox"/> Neoprene	<input type="checkbox"/> Nitrile	<input type="checkbox"/> Other: _____	
Protective Clothing: <input type="checkbox"/> Coverall and/or chemical suit (What Type?) _____					
<input type="checkbox"/> Footwear (What Type?) _____		<input type="checkbox"/> Eye/face/head protection (What Type?) _____			
<input type="checkbox"/> Other _____					
Respirator type:	<input type="checkbox"/> Disposable Resp.	<input type="checkbox"/> Half Face	<input type="checkbox"/> Full Face	<input type="checkbox"/> SCBA	<input type="checkbox"/> PAPR
Respirator filter efficiency or cartridge type:					

Completed by: Name: _____	Signature: _____	Date: _____
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Reviewed by Supervisor		
Name: _____	Signature: _____	Date: _____

Review by Department Safety Officer		
Name: _____	Signature: _____	Date: _____

Comments:

Review by Safety and Loss Prevention Unit of Risk Management. (This section is to be completed by the Safety and Loss Prevention Unit of Risk Management)	
Findings:	
Exposure Assessment:	
Recommendations:	

