COVID-19
FIRST RESPONDERS ONLY
EXPOSURE INVESTIGATION REPORT

DEPARTMENT / STATION ________________________ Date: ____________

Transport Unit # ______________ **Run#** ______________

Name of Employee ________________________

Address of Employee ________________________

Phone ( ) ________________________

BOCC Job Title ________________________

Place of Full Time Employment & Phone if Volunteer ________________________

Emp or Vol I.D. No. ____________ Address of Exposure ____________

Date of Exposure ____________ Time of Exposure ____________

Date Reported ____________ Time Reported ____________

Reported To ________________________

Action Taken by Employee: [ ] Reporting Only [ ] First Aid Only [ ] Sent to Doctor [ ] Sent to Hospital

Patient Taken To: [ ] Sent to Gulf Coast Medical Center [ ] Sent to Bay Medical Center [ ] Not Transported

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List all PPE Used by EE/Patient

What PPE Did EE Wear: [ ] Mask [ ] Gloves [ ] Safety Glasses/Face Shield [ ] Other

What PPE Did Patient Wear: [ ] Mask [ ] Gloves [ ] Safety Glasses/Face Shield [ ] Other

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Description of Possible Exposure

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CRITICALLY IMPORTANT: PLEASE LIST ALL FIRST RESPONDERS ON SCENE (BCSO, PCFD, PCBFD, Etc)

(Collecting for D.O.H.)

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Symptoms Presented by Patient(s)

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COVIN-19

FIRST RESPONDERS ONLY

EXPOSURE INVESTIGATION REPORT

Any Witness(es) to Exposure : ____________________

(Please attach witness(es) statement(s) to report) ____________________

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A FALSE STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION COMMITS INSURANCE FRAUD, PUNISHABLE AS PROVIDED IN S. 817.234.

Affected Person's Signature ____________________ **Date** ____________________

EMPLOYEE / VOLUNTEER STATEMENT

What Happened? ____________________

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INVESTIGATING SUPERVISOR'S REPORT COMMENTS

What Acts, Failures to Act And/Or Conditions Contributed Most Directly to This Incident? (Immediate Cause) ____________________

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What Action Has or Will Be Taken to Prevent Recurrence? ____________________

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Investigated By: ____________________ Title: ____________________

Please Print Name

Signature: ____________________ Date: ____________________

Bat/Division Chief Signature: ____________________ Date: ____________________

Chief/Dep. Chief
Emergency Services Signature: ____________________ Date: ____________________