

## Hazardous Chemical Exposure Incident Report

INSTRUCTIONS: Use the forms in this package to document routes and circumstances of a hazardous chemical exposure incident.

Hazardous Chemical Exposure Incident Report		
NAME OF FORM	PAGE	ACTION
Part 1	1 – 2	<ol style="list-style-type: none"><li>1. Completed by employee</li><li>2. Employee receives a copy</li><li>3. Human Resources receives a copy</li></ol>
Part 2	3	<ol style="list-style-type: none"><li>1. Completed by Environmental Health and Safety Officer</li><li>2. Employee receives a copy</li><li>3. Human Resources receives a copy</li></ol>
Part 3	4	<ol style="list-style-type: none"><li>1. Completed by Exposed Employee's Medical Care Provider</li><li>2. Medical Care Provider mails direct to Human Resources</li><li>3. Medical Care Provider mails direct to Environmental Health and Safety Officer</li></ol>
Part 3A	6	<ol style="list-style-type: none"><li>1. Completed by the Exposed Employee to record Medical Evaluation follow up</li><li>2. Employee mails direct to Human Resources</li><li>3. Employee mails direct to Environmental Health and Safety Officer</li></ol>
Part 3B	7	<ol style="list-style-type: none"><li>1. Completed by the Exposed Employee's Medical Care Provider to record Medical Evaluation Follow-up</li><li>2. Medical Care Provider mails direct to Human Resources</li><li>3. Medical Care Provider mails direct to Environmental Health and Safety Officer</li></ol>

## Hazardous Chemical Exposure Incident Report

### Part 1 (to be completed by Employee)

Please print or type all information

DEMOGRAPHICS					
Date (of form completion):	Department:		Work Telephone:		
Employee's Last Name:			Employee's First Name:		
Date of Birth:			Social Security #:		
Home Telephone #:			Other Contact # (i.e. mobile):		
EXPOSURE INCIDENT					
Date of Exposure:			Time of Exposure (be sure to note a.m. or p.m.):		
Where Did the Incident Take Place (be as specific as possible)?					
Nature of the Incident (i.e. injured body part, difficulty breathing, chemical burn, etc.)?					
What Tasks Were You Performing When the Exposure Took Place (please indicate if task(s) were routine or if they varied from your regular work duties). If varied, please explain why you were engaging in said activity(ies) [include additional page(s), as necessary]?					
List chemical(s), amount and concentration in use at time of exposure [include additional page(s), as necessary]:					
<b>Chemical Name</b>	<b>Amt.</b>	<b>Conc.</b>	<b>Chemical Name</b>	<b>Amt.</b>	<b>Conc.</b>
1.			2.		
3.			4.		

CONTROLS MEASURES			
Provide details about any control measures in use at the time of exposure (i.e. Fume Hood, Dust Mask, etc.):			
PERSONAL PROTECTIVE EQUIPMENT - PPE			
Were you wearing any Personal Protective Equipment (PPE) [i.e. safety glasses, lab coat, ear muffs, nitrile gloves, etc.]?:      YES      NO		If <b>YES</b> , Describe what type:	
Did the PPE Fail?      YES      NO		If <b>YES</b> , Describe how (provide additional detail below, as needed):	
Additional detail:			
INCIDENT EXPOSURE			
What Part(s) of your Body was Exposed?		Estimate the Size or Area of your Body that was Exposed:	
How Long Did The Exposure Last (# of seconds, min., hours, etc.)?			
Is a Safety Data Sheet (SDS) attached to this Report?		YES	NO
SIGNS AND SYMPTOMS			
Did you develop or experience any signs or symptoms as a result of the exposure?		YES	NO
If yes, list them below (i.e. headache, nausea, rash, etc.):			
1.	2.		
3.	4.		
5.	6.		
Are signs and symptoms currently present (at time of form completion)?		YES	NO
Are the signs and symptoms those documented on the SDS?		YES	NO      N/A
Is Exposure monitoring data available?		YES	NO      N/A

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

*As stipulated and in accordance with 29 CFR 1910.20, the Occupational Exposure to Hazardous Chemicals in Laboratories standard 29 CFR 1910.1450, form and related documentation will be kept on file by Farmingdale State College for the length of employment and 30 years thereafter. This form and related documentation will remain confidential. Personal identifying information will be released with your consent only.*

## Hazardous Chemical Exposure Incident Report

**Part 2** (to be completed by Environmental Health and Safety Officer)

**Please print or type all information**

DEMOGRAPHICS			
Date (of form completion):	Name of EH&S Officer Completing Form:	EH&S Officer Work Telephone:	
Employee's Last Name:		Employee's First Name:	
Employee Date of Birth:		Employee Social Security #:	
Employee Home Telephone #:		Employee Other Contact # (i.e. mobile):	
Is a Comprehensive Accident Report Detailing This Incident On file?		YES	NO
Is a SH 900 and Related Documents Detailing this Incident On File?		YES	NO      N/A
EH&S Officer Comment:			
EH&S OFFICER TO SUBMIT COMPLETED COPIES OF FORMS PART 1 AND 2 TO:			
[enter exposed employee's name and address]		Farmingdale State College ATTN: Marybeth Incandela Director of Human Resources Whitman Hall 2350 Broadhollow Road Farmingdale, NY 11735 ph. (934) 420-2107 fax (934) 420-2489 <a href="mailto:incandm@farmingdale.edu">incandm@farmingdale.edu</a>	

\_\_\_\_\_  
Environmental Health and Safety Officer's Signature

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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## Hazardous Chemical Exposure Incident Report

**Part 3** (to be completed by Exposed Employee's Medical Care Provider)

**Please print or type all information**

EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Date of Birth:	Social Security #:
Work Site Name:	Work Telephone:
MEDICAL CARE PROVIDER	
Health Care Professional Name:	Title:
Office Location (Street and Number, City, State, Zip):	
Office Telephone:	Office Fax Number:
MEDICAL CARE PROVIDER'S REPORT	
Did You Treat The Patient/Employee Directly?      YES      NO	
If <b>YES</b> , Specify Treatment Regimen [include additional page(s), as necessary]:	
Other Pertinent Information [include additional page(s), as necessary]:	

\_\_\_\_\_  
Medical Care Provider's Signature

\_\_\_\_\_  
Date

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**MEDICAL CARE PROVIDER  
TO SUBMIT COMPLETED  
COPY OF FORM PART 3 TO:**

Farmingdale State College  
ATTN: Marybeth Incandela  
Director of Human Resources  
Whitman Hall  
2350 Broadhollow Road  
Farmingdale, NY 11735  
ph. (934) 420-2107  
fax (934) 420-2489  
[incandm@farmingdale.edu](mailto:incandm@farmingdale.edu)

Farmingdale State College  
ATTN: Jeff Carter, CHMM, CHO, MPS  
Environmental Health and Safety Officer  
Horton Hall  
2350 Broadhollow Road  
Farmingdale, NY 11735  
ph. (934) 420-2105  
fax (934) 420-9173  
[carterj@farmingdale.edu](mailto:carterj@farmingdale.edu)

## Hazardous Chemical Exposure Incident Report

**Part 3A** (to be completed by Exposed Employee to record Medical Evaluation follow up)

**Please print or type all information**

EXPOSED EMPLOYEE		
Date (of form completion):	Department:	Work Telephone:
Employee's Last Name:	Employee's First Name:	Social Security #:
Job Title at Time of Exposure:	Date and Time of Exposure:	
Date of Follow Up:	Name and Location of Medical Treatment Facility:	
Reason for Follow Up:		
EMPLOYEE TO SUBMIT COMPLETED COPY OF FORM PART 3A TO:		
Farmingdale State College ATTN: Marybeth Incandela Director of Human Resources Whitman Hall 2350 Broadhollow Road Farmingdale, NY 11735 ph. (934) 420-2107 fax (934) 420-2489 <a href="mailto:incandm@farmingdale.edu">incandm@farmingdale.edu</a>	Farmingdale State College ATTN: Jeff Carter, CHMM, CHO, MPS Environmental Health and Safety Officer Horton Hall 2350 Broadhollow Road Farmingdale, NY 11735 ph. (934) 420-2105 fax (934) 420-9173 <a href="mailto:carterj@farmingdale.edu">carterj@farmingdale.edu</a>	
Supervisor's Statement/Comments (enter "N/A" if no additional information/detail warranted):		

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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## Hazardous Chemical Exposure Incident Report

**Part 3B** (to be completed by the Exposed Employee's Medical Care Provider to record Medical Evaluation follow up)

**Please print or type all information**

MEDICAL CARE PROVIDER			
Health Care Professional Name:	Title:		
Office Location (Street and Number, City, State, Zip):			
Office Telephone:	Office Fax Number:		
MEDICAL CARE PROVIDER'S REPORT			
Employee Health File Reviewed?	YES	NO	Date of Review:
Medical Care Provider's Findings & Observations:			
Is Additional Follow Up Needed (if so, explain why):			
Other Pertinent Information:			
MEDICAL CARE PROVIDER TO SUBMIT COMPLETED COPY OF FORM PART 3B TO:			
Farmingdale State College ATTN: Marybeth Incandela Director of Human Resources Whitman Hall 2350 Broadhollow Road Farmingdale, NY 11735 ph. (934) 420-2107 fax (934) 420-2489 <a href="mailto:incandm@farmingdale.edu">incandm@farmingdale.edu</a>		Farmingdale State College ATTN: Jeff Carter, CHMM, CHO, MPS Environmental Health and Safety Officer Horton Hall/Administration and Finance 2350 Broadhollow Road Farmingdale, NY 11735 ph. (934) 420-2105 fax (934) 420-9173 <a href="mailto:carterj@farmingdale.edu">carterj@farmingdale.edu</a>	

\_\_\_\_\_  
Medical Care Provider's Signature

\_\_\_\_\_  
Date

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