Please Note: This report is intended to be used for internal use only. It is not an acceptable Claims form and therefore should not be submitted to Glatfelter Commercial Ambulance.

Glatfelter Commercial Ambulance℠
A Division of Glatfelter Insurance Group

Incident Exposure Record

Name _____

Date of Birth _____ Social Security Number _____

Incident Number _____ Incident Date _____

Location of Incident _____

Description of Incident _____

_____

_____

_____

Type of Exposure: Inhalation _____

Direct Contact _____

Ingestion _____

Materials Exposed To _____

_____

Type of Decontamination _____

Length of Exposure (time) _____

Symptoms (if any) _____

_____

Treatment at Scene _____

_____

Name of Medical Facility _____

Treatment Rendered _____

Protective Clothing and Equipment Used During Incident (list) _____

_____

_____

Additional Information _____

_____

_____

Provider's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Safety Officer/Committe's Analysis

What acts, failures to act and/or conditions contributed most directly to this accident? (Immediate Cause)

What are the basic or fundamental reasons for the existence of these acts and/or conditions? (Fundamental Cause)

What action has or will be taken to prevent recurrence? Place "X" by items completed.

Comments

Signature: Date:

(Rev. 9/15)