|  |  |
| --- | --- |
|  | Date: |
|  | Name: |
| **Exposure, Injury, and Dosimetry Tracking Form** |
| **For Activities Performed the Month of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or between:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****1.** During this reporting period, did you work at a job site where oil, hazardous chemicals, radiation, biohazards, or other sources of exposure were or may have been present? [ ]  Yes [ ]  No If Yes, please provide details for each trip: |
| **Site**(name, location, ID) | **Dates****Present****on Site** | **Exposure Sources**(chemical, physical, biological, ergonomic) | **Exposure**(# of days, hours per day, exposure level, if known) | **Level(s) of PPE****Used** | **EPA TLD****(dosimeter)****Worn?** | **Symptoms from Exposure** | **Job Duties** |
|  |  |  |  |  | [ ]  Yes[ ]  No |  |  |
|  |  |  |  |  | [ ]  Yes[ ]  No |  |  |
|  |  |  |  |  | [ ]  Yes[ ]  No |  |  |
|  |  |  |  |  | [ ]  Yes[ ]  No |  |  |
| **2.** Did you receive an on-the-job significant exposure (chemical, physical, biological, ergonomic) during this reporting period? [ ]  Yes [ ]  No [ ]  UnknownIf Yes, indicate date of exposure \_\_\_/\_\_\_/\_\_\_\_. Notify your supervisor to complete and file the *OSHA & EPA 301 Injury, Illness and Near Miss Report*. Complete [Form CA-1](http://www.dol.gov/owcp/regs/compliance/ca-1.pdf) or [Forms CA-2](http://www.dol.gov/owcp/regs/compliance/ca-2.pdf) and [CA-35](http://www.dol.gov/owcp/regs/compliance/ca-35.pdf) within 24 hours of the incident (or date you realized illness, if applicable, was caused/aggravated by employment) and submit to your supervisor.  |
|  |
| **3.** Were you injured on the job or did you experience a job-related illness this reporting period? [ ]  Yes [ ]  No [ ]  UnknownIf Yes, indicate date of injury/illness \_\_\_/\_\_\_/\_\_\_\_. Notify your supervisor to complete and file the *OSHA & EPA 301 Injury, Illness and Near Miss Report*. Complete [Form CA-1](http://www.dol.gov/owcp/regs/compliance/ca-1.pdf) or [Forms CA-2](http://www.dol.gov/owcp/regs/compliance/ca-2.pdf) and [CA-35](http://www.dol.gov/owcp/regs/compliance/ca-35.pdf) within 24 hours of the incident (or date you realized illness, if applicable, was caused/aggravated by employment) and submit to your supervisor.  |
|  |
| 4. Did your electronic personal dosimeter alarm sound at any time while wearing it? [ ]  Yes [ ]  No If Yes, complete the Individual Radiation Exposure Record located at <http://www.epaosc.net/radresources>  |
| Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) (Signature)*[Supervisors: Forward a completed copy of this form to the local SHEMP Manager (or another designated person) at least quarterly.]* |