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U.S. DEPARTMENT OF COMMERCE
NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY

INJURY/ILLNESS/EXPOSURE ASSESSMENT

Name:	Position Title:	Div.#:
Mailing Address:	Incident Location:	Ext.:

Date/Time of Incident:	Date/Time of Treatment:

Describe Briefly What Happened (as related by patient):

**Chemical exposure/involvement. Name of Material(s): _____

Indicate personal protective equipment used: ☐ Safety Glasses ☐ Goggles ☐ Respirator ☐ Gloves ☐ Other: _____

Supervisor/Sponsor Name:	Supervisor/Sponsor Ext.:	Has he/she been notified? ☐ Yes ☐ No

Comments of Attending Physician/Nurse (extent of injuries, condition, etc.):

Patient Referred to:

Incident Classification: ☐ Medical Treatment (on-site) ☐ Medical Treatment (off-site) ☐ First Aid ☐ Repeat First Aid

Attending Physician/Physician Assistant/Nurse (Signature):	Date:

Comments/Follow-up:

Which OWCP Forms were given?: ☐ CD-137 ☐ None ☐ CA-1 ☐ CA-2 ☐ CA-16 ☐ CA-17 ☐ OWCP 1500

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Commerce/DEPT-18: Employees Personnel Files Not Covered by Notices of Other Agencies
OPM/GOVT-10: Employee Medical File System Records

Disclosure: Furnishing this information is voluntary. For Health Unit information collections, individuals have opportunity to decline providing information, however, care may be affected and future retrievability will be impacted. Submitting voluntary information constitutes your consent to the use of the information for the stated purpose. When you submit the form, you are indicating your voluntary consent for NIST to use of the information you submit for the purpose stated.