

**Appendix D:**  
Epidemiologic Contact Assessment Symptom Exposure  
**EPI CASE SURVEY SAMPLE**

Appendix D. Epidemiologic Contact Assessment Symptom Exposure (Epi CASE) Survey

Form Approved  
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Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reading instructions, obtaining signatures, and completing interview. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0923-0051)

Version 08262019

INCIDENT CODE:|\_|\_| SITE #|\_|\_| INTERVIEWER ID|\_|\_| DATE:|\_|\_|-|\_|\_|-|\_|\_|\_|\_|\_| Registrant ID \_\_\_\_\_  
 TIME STARTED |\_|\_|:|\_|\_||\_| TIME ENDED |\_|\_|:|\_|\_||\_| M M D D Y Y Y Y  
H H M M A/P H H M M A/P

<b>IDENTIFICATION PROVIDED</b>	
<input type="checkbox"/> <b>Social Security</b> _____ - ____ - ____ <input type="checkbox"/> <b>Driver's license:</b> State _____ Number _____ exp ____ / ____ / ____	<input type="checkbox"/> <b>State ID:</b> State ____ Number _____ exp ____ / ____ / ____ <input type="checkbox"/> <b>Other ID (describe)</b> _____
<b>REGISTRANT PERSONAL INFORMATION</b>	
<b>1. Name</b> _____, _____ <small>Last First M.I.</small> <b>2. Date of Birth (mm/dd/yyyy)</b> ____/____/____	<b>5. Social media account (check all that apply and specify)</b> Facebook _____ <input type="checkbox"/> Twitter _____ <input type="checkbox"/> Instagram _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Refused <input type="checkbox"/>
<b>3. A. Street</b> _____ City _____ County _____ State _____ ZIP _____ <b>B. How many children younger than 13 years were in your immediate care during the incident?</b> _____ If 1 or more, complete Question 19 AFTER completing Questions 4–18.	<b>6. What are the best telephone numbers to reach you?</b> A. (____) ____-____ Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> B. (____) ____-____ Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/>
<b>4. Email</b> _____	<b>7. Sex (circle one)</b> Male Female Other (specify) _____ <b>8. If female, (circle one)</b> Pregnant Not pregnant Don't know/refused
<b>EMERGENCY CONTACT INFORMATION (Must live at a different address than registrant)</b>	
<b>9. Name</b> _____, _____, _____ <small>(Last, First, M.I.)</small>	<b>11. Email</b> _____
<b>10. Street address</b> _____ City _____ County _____ State ____ ZIP _____	<b>12. What are the best telephone numbers to reach them?</b> A. (____) ____-____ Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> B. (____) ____-____ Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/>

**EXPOSURE INFORMATION on [DATE] at [TIME]**

**13. Were you exposed to this incident as (check all that apply):**

- Facility employee (if applicable)
- Passerby       First responder
- Clean-up worker or volunteer
- Government official (including military)
- Resident    ➡ **Skip to Question 15**
- Other \_\_\_\_\_

**14. A. Street address** \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

**B. Nearest intersection/building/landmark**

\_\_\_\_\_

**15. Physical location (check all that apply)**

- Inside building     Outside     Inside a car/vehicle
- Other \_\_\_\_\_

**HEALTH/NEED**

**16. As a result of this incident, did you get injured or ill?**  
*Refer to Epi CASE Symptom Checker for codes*

- Yes
- No
- Don't know/refused

**17. As a result of this incident, are you personally in need of anything? (check all that apply)**

- Medicine or medical supplies     Medical care
- Mental health care     Water     Shelter     Food
- Utilities     Transportation
- Other, specify \_\_\_\_\_
- Don't know/refused

**18. For radiological and nuclear incidents only: If you had repeated vomiting AFTER the incident, how long after the incident [date and time] did it start? (circle one)**

less than 1 hour      1-2 hours      3-6 hours

more than 6 hours      Did not vomit      Don't know/Refused

**CHILDREN YOUNGER THAN 13 YEARS IN YOUR IMMEDIATE CARE DURING THE INCIDENT**

**19. For each child, please provide the date of birth or age, sex, and injuries or illness that resulted from this incident. Refer to the Epi CASE Symptom Checker for codes.**

	Date of birth (mm/dd/yyyy)	Age (years)	Sex (circle one)		Child's injury or illness				
1.	__/__/____	____	Male	Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	__/__/____	____	Male	Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	__/__/____	____	Male	Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	__/__/____	____	Male	Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	__/__/____	____	Male	Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>