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Form Approved

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Exp. Date 03/31/2018

Interviewer\_\_\_\_\_\_\_\_\_\_ Household ID\_\_\_\_\_\_\_\_\_\_\_ Participant ID \_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Start time \_\_\_\_\_\_\_\_\_\_\_\_\_ End time \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **SECTION I: ACE ADULT SURVEY**

## **General Survey Module A: Location/Exposure**

I would like to begin by showing you a map of the areas affected by [Description of Incident] on [Date]. The affected areas are highlighted. From now on, I will refer to the [Description of Incident] on [Date] as “the incident.”

After reviewing a map of the exposed area(s), ask respondents the following questions:

1. Were you in this area at any time between [Incident Date/Time] and [End Date/Time]?

Yes

No Arrow pointing to instructions following the response Say to the respondent: Thank you for your time.

Record the end time and do not ask any further questions. This person is not eligible for the survey.

1. I would like to know about each place you went within the highlighted area on the map between [Incident Date] at [Time] and [End Date/Time] so that I can construct a timeline and understand what happened when you were exposed. Record the following answers in the table provided. Fill out the table for one location before continuing on to the next location.

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|  | Location 1: | Location 2: | Location 3: |
| --- | --- | --- | --- |
| 1. What is the address of where you (first/next) were during the incident? Probe for as much location information as possible. Then, continue to b. Do not ask about all locations first. Collect all information about one location before continuing to the next. |  |  |  |
| 1. How long were you in this location? Record whether in minutes or hours. |  |  |  |
| 1. Were you inside or outside while you were there? If outside, skip questions d, e, and f. | In Out | In Out | In Out |
| 1. If inside, were there any open windows while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. If inside, was there any ventilation, such as an [air conditioner/heater] running, while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. If respondent said “yes” for d or e, circle “no” for f and skip to next question. Otherwise, if inside, ask: did you shelter in place, meaning staying inside, with doors and windows closed and all ventilation systems turned off?   If yes, ask the respondent: Please describe what you did to shelter in place. | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. Did you smell an odor? If no or unsure skip questions h and i. | Yes No Unsure | Yes No Unsure | Yes No Unsure |
| 1. Can you please describe the odor? |  |  |  |
| 1. Would you describe the odor as light, moderate or severe? | Light Moderate Severe | Light Moderate Severe | Light Moderate Severe |
| 1. Were you in a [smoke cloud/dust/fog] while you were there? | Yes No Unsure | Yes No Unsure | Yes No Unsure |

1. Did you evacuate from the highlighted area on the map?

Yes

No Arrow pointing to instructions following the response Go to Question A5

1. At approximately what time did you evacuate?

\_\_\_\_:\_\_\_\_\_ AM PM

Hour Min

1. How did you evacuate?

Ambulance

Privately-owned vehicle

Bus

Other (Please specify):

1. Is there any additional information that you think we should know about your exposure?

Yes Arrow pointing to instructions following the response Record the information on the lines provided below

No Arrow pointing to instructions following the response Continue to Question A7

1. Were you decontaminated, meaning your clothing was removed or your body was washed?

Yes

No Arrow pointing to instructions following the response Go to next module

1. How were you decontaminated? Read all answer choices aloud to the respondent and check all that apply.

Clothing Removal

Water

Soap and Water

Other (Please specify):

1. Where were you decontaminated? If respondent needs clarification, specify that this question is asking for a geographic location, not a place on their body.

1. At approximately what time were you decontaminated?

\_\_\_\_:\_\_\_\_\_ AM PM

Hour Min

## **General Survey Module B: Health Status**

Now I would like to ask you some questions about any symptoms you may have experienced after the incident.

1. Within 24 hours of the incident, did you have any symptoms of an illness?

Yes

No Arrow pointing to instructions following the response Go to next module

1. I’m going to ask you some questions about symptoms that could be related to the [Chemical] that was released. Fill out the table provided below. Repeat B2 for one symptom and check the boxes that apply before asking about the next symptom.

|  | 1. Did you experience [Symptom] within 24-hours of the incident? If yes, go to ii. If no, repeat i for next symptom. | | 1. Were you experiencing [Symptom] before the incident? If yes, go to iii. If no, go to iv. | | 1. Was your [Symptom] worse after the incident? Continue to iv (if listed); otherwise, repeat i for next symptom. | | 1. Are you still experiencing [Symptom]? Repeat i for next symptom. | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Symptom | Yes | No | Yes | No | Yes | No | Yes | No |
| Irritation/pain/ burning of eyes |  |  |  |  |  |  |  |  |
| Increased tearing |  |  |  |  |  |  |  |  |
| Blurred vision/double vision |  |  |  |  |  |  |  |  |
| Runny nose |  |  |  |  |  |  |  |  |
| Burning nose or throat |  |  |  |  |  |  |  |  |
| Burning lungs |  |  |  |  |  |  |  |  |
| Increased salivation |  |  |  |  |  |  |  |  |
| Ringing of the ears |  |  |  |  |  |  |  |  |
| Difficulty swallowing |  |  |  |  |  |  |  |  |
| Odor on breath (Gasoline or other, specify) |  |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |  |
| Dizziness or lightheadedness |  |  |  |  |  |  |  |  |
| Loss of consciousness/fainting |  |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |  |
| Numbness, pins and needles, or funny feeling in arms or legs |  |  |  |  |  |  |  |  |
| Confusion |  |  |  |  |  |  |  |  |
| Difficulty concentrating |  |  |  |  |  |  |  |  |
| Weakness of arms |  |  |  |  |  |  |  |  |
| Weakness of legs |  |  |  |  |  |  |  |  |
| Muscle twitching |  |  |  |  |  |  |  |  |
| Tremors in arms or legs |  |  |  |  |  |  |  |  |
| Loss of balance |  |  |  |  |  |  |  |  |
| Breathing slow |  |  |  |  |  |  |  |  |
| Breathing fast |  |  |  |  |  |  |  |  |
| Difficulty breathing/feeling out-of-breath |  |  |  |  |  |  |  |  |
| Coughing |  |  |  |  |  |  |  |  |
| Increased congestion or phlegm |  |  |  |  |  |  |  |  |
| Wheezing in chest |  |  |  |  |  |  |  |  |
| Slow heart rate/pulse |  |  |  |  |  |  |  |  |
| Fast heart rate/pulse |  |  |  |  |  |  |  |  |
| Chest tightness or pain/angina |  |  |  |  |  |  |  |  |
| Blue or gray coloring of ends of fingers/toes or lips |  |  |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |  |  |
| Non-bloody vomiting |  |  |  |  |  |  |  |  |
| Non-bloody diarrhea |  |  |  |  |  |  |  |  |
| Bloody vomiting |  |  |  |  |  |  |  |  |
| Blood in stool/diarrhea |  |  |  |  |  |  |  |  |
| Abdominal pain |  |  |  |  |  |  |  |  |
| Fecal incontinence or inability to control bowel movements |  |  |  |  |  |  |  |  |
| Irritation, pain, or burning of skin |  |  |  |  |  |  |  |  |
| Skin rash |  |  |  |  |  |  |  |  |
| Skin blisters |  |  |  |  |  |  |  |  |
| Sweating |  |  |  |  |  |  |  |  |
| Cool or pale skin |  |  |  |  |  |  |  |  |
| Skin discoloration |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |
| Agitation/irritability |  |  |  |  |  |  |  |  |
| Fatigue/tiredness |  |  |  |  |  |  |  |  |
| Difficulty sleeping |  |  |  |  |  |  |  |  |
| Feeling depressed |  |  |  |  |  |  |  |  |
| Generalized weakness |  |  |  |  |  |  |  |  |
| Diffuse muscle aches and pains |  |  |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |  |  |
| Urinary incontinence or dribbling pee |  |  |  |  |  |  |  |  |
| Inability to urinate or pee |  |  |  |  |  |  |  |  |
| Any other symptoms? If yes, What was it? Record below. |  |  |  |  |  |  |  |  |
| 1. |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |

## **General Survey Module C: Fire/Explosion**

1. Were you injured as a result of the fire or explosion?

Yes

No Arrow pointing to instructions following the response Go to next module

1. I’m going to ask you some questions about injuries that can happen as a result of a fire or explosion. For some of these injuries, I’m going to ask you where on your body they were located. Fill out the table below. Repeat C2 i-ii for one injury and check the boxes that apply before asking about the next injury.

|  | 1. Did you experience [Injury] within 24-hours after the fire or explosion? If yes, go to C2 ii. If no, repeat C2 i for next injury. | | 1. If Yes, where on your body was it located? Repeat C2 i for next injury. |
| --- | --- | --- | --- |
| Injury | Yes | No |
| Abrasion/scrape |  |  |  |
| Broken bone/fracture |  |  |  |
| Bruise |  |  |  |
| Cut |  |  |  |
| Dislocation |  |  |  |
| Sprain or strain |  |  |  |
| Burn |  |  |  |
| Crush injury |  |  |  |
| Severe bleeding |  |  |  |
| Ear drum puncture |  |  |  |
| Hearing loss |  |  |  |
| Ringing in ears |  |  |  |
| Whiplash |  |  |  |
| Concussion |  |  |  |
| Bowel perforation |  |  |  |
| Eye injury |  |  |  |
| Any other injuries? If yes, what was it? If applicable, specify where on your body was it located? Record below. | | | |
| 1. | | |  |
| 2. | | |  |

## **General Survey Module D: Medical Care**

1. Did you receive medical care or a medical evaluation because of the incident?

Yes 🡺 Go to Question D3

No

1. Why didn’t you seek medical care?

Did not have symptoms

Symptoms were not bad enough

Don’t like to go to the doctor

Didn’t want to take time

Worried about who would pay for the medical visit

Worried about losing job

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unsure

For those individuals who did not seek medical care, go to the next module.

1. Were you provided with care by an EMT or paramedic?

Yes

No 🡺 Go to Question D5

1. On what date were you provided care by an EMT or paramedic?

\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

MM DD YYYY

1. Were you provided with care at a hospital?

Yes

No 🡺 Go to Question D15

1. On what date were you first provided care at a hospital? If you had any additional visits to the hospital, please provide me the dates of those visits. Record the date that the respondent first went to the hospital and then the date of any subsequent visits.

1st date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

MM DD YYYY

2nd date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

MM DD YYYY

3rd date of hospital visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

MM DD YYYY

1. What is the name of the hospital(s)?

1. How did you get to the hospital? If the respondent had more than one hospital visit, tell them that you are referring to their first visit.

EMS/Ambulance

Drove self

Driven by relative, friend, or acquaintance

Other (Please specify):

1. Were you treated only in the emergency department or were you admitted to the hospital?

Treated in emergency department (Outpatient) 🡺 Go to Question D15

Admitted (Hospitalized)

1. How many nights were you hospitalized, including any nights in an intensive care unit (ICU)?

\_\_\_\_\_\_\_\_ Nights

1. Were you placed in an Intensive Care Unit or ICU?

Yes

No 🡺 Go to Question D15

1. How many nights were you in the ICU?

\_\_\_\_\_\_\_\_ Nights

1. Were you on a ventilator?

Yes

No 🡺 Go to Question D15

1. How many nights were you on a ventilator?

\_\_\_\_\_\_\_\_ Nights

1. Besides at a hospital or by an EMT or paramedic, were you seen by a doctor or other medical professional?

Yes

No 🡺 Go to Question D17

1. Read i–iv to the respondent and record information in the table below.

| 1. On what dates were you provided care by a doctor or other medical professional? (mm/dd/yyyy) | 1. What is the name of the doctor or other medical professional? | 1. What service did this doctor or medical professional provide? | 1. What is the address of the office? |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Were you prescribed any new medicines when you were examined after the incident?

Yes

No 🡺 Go to Question D19

1. What is the name of the medicine or medicines you were prescribed? If respondent does not know the name of the medication, ask: What is the medicine for?

1. Please tell me if any of the following describe why you sought medical care. Read questions a-c to the respondent and circle the appropriate answer(s).
   1. You were given instructions to seek medical care? Yes No Unsure
   2. You experienced health problems or symptoms   
      within 24 hours of the incident? Yes No Unsure
   3. You were worried about possible health   
      problems associated with the incident? Yes No Unsure

If aged 13–17, read: We will be doing medical chart reviews and will be asking your parent or guardian for permission to review your medical record for the visit related to the incident. Continue to next module.

If aged 18 or older, go to Question D20.

1. If aged 18 or older, read: To improve future responses, we try to study medical emergency response as thoroughly as possible. Are you willing to let us get a copy of your medical records for the medical treatment you received because of the incident?

Yes 🡺 Review the medical records release form with the respondent and collect their signature

No

## **General Survey Module E: Occupational History**

Now I’m going to ask you some questions about your work experiences—paid, volunteer, or military—from [12 months ago] to [current date]. This includes part-time and full-time jobs that lasted one month or more, such as jobs for pay inside or outside the home or jobs on a farm.

1. Are you currently employed?

Yes Arrow pointing to instructions following the response Go to Question E3

No

1. Did you have a job in the last 12 months, that is, since [12 months ago]?

Yes

No Arrow pointing to instructions following the response Go to Question E4

1. If you had more than one job in the last 12 months, please tell me about the most recent job first, then the next most recent. Fill-out the table below; complete the information for the first job completely before asking about the next job. Once information about all jobs that the respondent has had in the past 12 months has been collected, go to the next module.

|  | Job 1 | Job 2 |
| --- | --- | --- |
| 1. What (is/was) the name of the company you (work/worked) for? |  |  |
| 1. What (does/did) this company make or do? |  |  |
| 1. What (is/was) your job title? |  |  |
| 1. (Does/Did) this job include working with or around any chemicals? If no or unsure, go to f. | Yes No Unsure | Yes No Unsure |
| 1. If yes, what chemicals (do/did) you work with or around? |  |  |
| 1. Did you have any other jobs since [12 months ago]?    * 1. Yes Arrow pointing to instructions following the response Repeat E3 for the next, most recent job (If the interviewee has had   more than 2 jobs, write details on a supplemental table). Circle ‘yes’ if you need to write information about a job on a supplemental table. Circle ‘no’ if all information collected is contained in this table. Once information about all jobs that the respondent has had in the past 12 months has been collected, continue to Question E4.   * + 1. No Arrow pointing to instructions following the response Continue to Question F1 | | |

## **General Survey Module F: Medical History**

Now I’m going to ask you a few questions about illnesses you may have had and the kinds of medicines you may have used.

1. Prior to the incident, have you ever been told by a doctor or other health care provider that you have or had any of the following medical conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

| Medical Condition |  |
| --- | --- |
| 1. Allergies? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure |
| 1. Asthma? | Yes  No  Unsure |
| 1. Diabetes? | Yes  No  Unsure |
| 1. High blood pressure? | Yes  No  Unsure |
| 1. Chronic obstructive pulmonary disease (COPD) or emphysema? | Yes  No  Unsure |
| 1. Heart Disease? | Yes  No  Unsure |
| 1. Physical disability that hinders mobility? | Yes (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure |
| 1. Psychological condition such as anxiety, depression or dependence disorder? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure |
| 1. Cancer? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure |
| 1. Immune disorders such as lupus, rheumatoid arthritis, or HIV? | Yes  No  Unsure |
| 1. Neurological conditions such as Parkinson’s disease or multiple sclerosis? | Yes  No  Unsure |
| 1. Any other medical conditions? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unsure |

Prior to the incident, were you taking any medicines? This includes medicines prescribed by a health care provider and those you might have gotten without a prescription from stores, pharmacies, friends, or relatives.

Yes

NoArrow pointing to instructions following the response Go to Question F4

Don’t Know Arrow pointing to instructions following the response Go to Question F4

1. What medicines were you taking? If respondent does not know the name of the medication, ask: What was the medicine for?

1. Do you currently smoke cigarettes, cigars, or pipes?

Yes Arrow pointing to instructions following the response Go to instruction box before Question F7

No

1. Have you smoked regularly in the past?

Yes

No Arrow pointing to instructions following the response Go to instruction box before Question F7

1. When did you last quit? Was it…Read all choices to the respondent.

Less than one year ago

1–2 years ago

3–4 years ago

5 or more years ago

If respondent is male, go to next module

1. Are you currently pregnant?

Yes

No

Don’t Know

1. Are you currently breastfeeding?

Yes

No

## **General Survey Module G: Emergency Response**

1. Were you a firefighter, police officer, or other professional who responded to the incident? If yes and necessary, probe for type of responder.

Firefighter

Police officer

EMS responder

Hospital emergency department worker

Other: Please specify

Not a responder 🡺 Go to next module

1. What specifically was your role during the response?

If an EMS responder, hospital emergency department worker, or other health care provider, go to Question G4. Otherwise, continue to Question G3.

1. Please look at this list and tell me what level of PPE you were wearing when you responded to the incident. Present Showcard Side A.

None

Level “A”

Level “B”

Level “C”

Level “D”

Firefighter turn-out gear with respiratory protection.

Firefighter turn-out gear without respiratory protection.

Other types of protection (such as gloves, eye protection, hardhat, steel-toed shoes)

If selected, ask: Please specify the type of protection:

Go to next module

If an EMS responder, hospital emergency department worker, or other health care provider, go to Question G4. Otherwise, continue to next module.

1. Please look at this list and tell me what type of protection you were wearing.  
   Present Showcard Side B

None

Non-sterile exam gloves

Surgical gloves

Face mask without protective shield

Face mask with protective shield

Non-splash resistant disposable gown

Splash resistant disposable gown

Protective eye glasses/goggles

Supplied air respirator

Respirator with cartridge/HEPA filters

If selected, ask: Please specify the type of cartridge/filter:

Other

If selected, ask: Please specify the type of protection:

## **General Survey Module H: Communication**

If respondent is an emergency responder, go to next module.

Now I would like to ask you a few questions about the communication you may have received regarding the incident.

If respondent is aged 13-17, continue to Question H1. Otherwise, go to Question H2.

1. If respondent is an adult, skip to Question H2. If respondent is aged 13-17, read: How did you hear about the incident?

Go to Question H3

1. Fill in the table below. Ask H2 i and only check the box next to the type of information the respondent received first. Then follow-up with H2 ii for the information the respondent received first. Continue to H2 iii and check all boxes that apply and follow-up with H2 iv for each type of follow-up information the respondent received.

| Source of Information | 1. How did you first receive information or instructions about the incident? Check only one box. | 1. Was the information you first received timely? Was it accurate? Write yes, no, or DK (for don’t know) in the appropriate box. | | 1. How did you receive follow-up information or instructions about the incident? Check all that apply. | 1. Was the follow-up information you received from [source] timely? Was it accurate? Write yes, no, or DK (for don’t know) in the appropriate box. | |
| --- | --- | --- | --- | --- | --- | --- |
| Source of Information |  | Timely | Accurate |  | Timely | Accurate |
| Directly from person in authority (i.e. police, firefighter, Hazmat official, supervisor) |  |  |  |  |  |  |
| TV |  |  |  |  |  |  |
| Radio |  |  |  |  |  |  |
| Two-way radio |  |  |  |  |  |  |
| Newspaper |  |  |  |  |  |  |
| Relative/friend/neighbor/  coworker |  |  |  |  |  |  |
| Website |  |  |  |  |  |  |
| Reverse 911 call |  |  |  |  |  |  |
| Phone call |  |  |  |  |  |  |
| Text message on a cell phone |  |  |  |  |  |  |
| Email |  |  |  |  |  |  |
| Community Meeting |  |  |  |  |  |  |
| Other, Specify: |  |  |  |  |  |  |

1. In the future, what are the best ways for your local authorities or the health department to reach you with information regarding a chemical incident? Check all that apply:

TV

Radio

Newspaper

Website

Phone call

Text message on a cell phone

Email

Community meeting

Other (Please specify):

## **General Survey Module I: Needs**

If respondent is an emergency responder, go to next module.

1. As a result of the incident, do you need any of the following…

Read all choices to the respondent.

* 1. Medicines or supplies Yes No
  2. Medical care Yes No
  3. Water Yes No
  4. Food Yes No
  5. Shelter Yes No
  6. Utilities Yes No
  7. Anything else Yes No

If yes, please specify:

1. If needs are identified in Question I1, obtain details on exactly what is needed so this can be provided to the state health department. Otherwise, continue to the next module.

## **General Survey Module J: Exposure of Other People Present**

1. Were there any other individuals present with you in the highlighted area of the map during the incident? Show highlighted area of the map.

Yes

No 🡺 Go to next module

1. In order to accurately evaluate the impact of the incident, we are trying to interview as many people who were in the area as possible. Fill in the following table with the information given for Question J2 a-c.
   1. Can you tell me the names of everyone else who was present with you during the incident?
   2. Which are children, and what are their ages?
   3. Can you tell me the phone number and e-mail address of the people who do not live with you?

| Name | Age  (if child) | Phone | E-mail |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## **General Survey Module K: Pets**

1. Did you have any pets or assistance animals that were in the highlighted area of the map during the incident? Show highlighted area of the map.

Yes

No 🡺 Go to next module

1. How many of your pets or assistance animals were in the highlighted area during the incident?

\_\_\_\_\_\_\_\_ Pets/Assistance animals

We will ask further questions about your pet(s) or assistance animal(s) separately at the completion of this survey.

Continue to next module

## **General Survey Module L: Demographic and Contact Information**

Now, I have some general questions about you.

1. Do you consider yourself to be Hispanic or Latino?

Yes

No

1. What race do you consider yourself to be?

Check all that apply:

Black or African American

White

Asian

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

1. What is the highest level of education you completed?

Grade 8 or Less

Some High School

High School Graduate or Equivalent

Some University/College

Technical or Trade School

Junior or Community College

University/College Graduate

Graduate School or Higher

1. If necessary, ask. Otherwise, check appropriate box. Are you male or female?

Male

Female

If respondent is registered in the Rapid Response Registry (RRR), read and verify RRR information. If changes are needed, enter them into Questions L5–L9, then go to Question L10.

If not in RRR, ask Questions L5–L9, and then continue on to Question L10.

1. What is your date of birth?

\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  
MM DD YYYY

1. What is your current address?

Street Apt

City State \_\_ \_\_ Zip Code:

1. What is the best telephone number to reach you? Please specify if this is a cellular phone, house phone, or work phone.

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ ‑ \_\_ \_\_ \_\_ \_\_

Cell

House

Work

1. Are there any more telephone numbers where you can be reached?

If yes, collect all other numbers and specify whether cell, house, or work number.

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ ‑ \_\_ \_\_ \_\_ \_\_

Cell

House

Work

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ ‑ \_\_ \_\_ \_\_ \_\_

Cell

House

Work

1. Do you have an email address where you can be reached?

Yes

No🡺 Go to Question L10

What is your email address?

1. We may want to interview you again in the future to check up on your health. Keeping in mind that people move, we would like to get a little more information to help us locate you in the future. In case you move to another residence, could we have the names and contact information of three people who live outside of your household and who would always know how to find you?

Yes 🡺 Complete the table provided

No 🡺 Go to next module

|  | Person 1 | Person 2 | Person 3 |
| --- | --- | --- | --- |
| First and Last Name |  |  |  |
| Address |  |  |  |
| Phone Number  (including area code) |  |  |  |
| Email Address |  |  |  |
| Relationship to you  (parent, child, sibling, other relative, friend, other) |  |  |  |

## **General Survey Module M: Supplemental Questions**

1. [Insert event specific questions requested by the local health department here].

**General Survey Module N: Conclusion Statements**

1. Is there anything else you want to tell us related to the [chemical] incident?

1. If Exposure of Other People Present Module did not identify children under the age of 13 that were present, go to Question N3. If children under the age of 13 were identified, read: I would now like to ask you some questions regarding any children you have under the age of 13 that were with you when you were in the highlighted areas of the map.

Refer to Module J to recall child’s name and then go to the Child Survey Section

1. If the Pets Module did not identify that the respondent had a pet or assistance animal in the highlighted area of the map during the incident, go to the “Closing Statement.” If pets or assistance animals were identified, read: I would now like to ask you some questions regarding any pets or assistance animals you have that were in the highlighted areas of the map.

Go to the Pet Survey Section

**Closing Statement:**

That completes this survey. I would like to sincerely thank you for your time. Be sure to record the end time on the first page of this survey.