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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

IDENTIFICATION PROVIDED	
<input type="checkbox"/> Social Security _ _ - _ - _ _ _ <input type="checkbox"/> Driver's license: State _ _ Number _ _ _ _ _ exp _ / _ / _ _ _	<input type="checkbox"/> State ID: State _ _ Number _ _ _ _ _ exp _ / _ / _ _ _ <input type="checkbox"/> Other ID (describe) _ _ _ _ _
REGISTRANT PERSONAL INFORMATION	
1. Name _ _ _ _ _ , _ _ _ _ _ <div style="display: flex; justify-content: space-between; width: 100%;"> Last First M.I. </div> 2. Date of Birth (mm/dd/yyyy) _ _ / _ _ / _ _ _ _	5. Social media account (check all that apply and specify) Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Instagram <input type="checkbox"/> Other <input type="checkbox"/> <div style="text-align: right;">Refused <input type="checkbox"/></div>
3. A. Street _ _ _ _ _ City _ _ _ _ _ County _ _ _ _ _ State _ _ _ _ _ ZIP _ _ _ _ _ B. How many children younger than 13 years were in your immediate care during the incident? _ If 1 or more, complete Question 19 AFTER completing Questions 4–18.	6. What are the best telephone numbers to reach you? 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"/>
4. Email _ _ _ _ _	7. Sex (circle one) Male Female Other (specify) _ _ _ _ _ 8. If female, (circle one) Pregnant Not pregnant Don't know/refused
EMERGENCY CONTACT INFORMATION (Must live at a different address than registrant)	
9. Name _ _ _ _ _ , _ _ _ _ _ , _ _ _ _ _ <div style="display: flex; justify-content: space-between; width: 100%;"> (Last, First, M.I.) </div>	11. Email _ _ _ _ _
10. Street address _ _ _ _ _ City _ _ _ _ _ County _ _ _ _ _ State _ _ _ ZIP _ _ _ _ _	12. What are the best telephone numbers to reach them? 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="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	___/___/____	____	Male	Female	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	___/___/____	____	Male	Female	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	___/___/____	____	Male	Female	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	___/___/____	____	Male	Female	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>