

Occupational History for Firefighters – Part I: Primary Work

Please complete the form, beginning with your present job, and list all jobs or military service you have held, either full-time or part-time, in order of date. Please indicate or not whether you had a work-related illness or injury at each job.

	List of potential hazards you were exposed to, such as:	Did you suffer a work-related illness or injury? Check Yes or No for each employment below. Please explain each Yes answer.																																				
Name	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><u>Physical</u></td> <td style="width: 25%;"><u>Chemical</u></td> <td style="width: 25%;"><u>Biological</u></td> <td style="width: 25%;"><u>Psychological</u></td> </tr> <tr> <td>Noise</td> <td>Mercury</td> <td>Viruses</td> <td>Boredom</td> </tr> <tr> <td>Radiation</td> <td>Lead</td> <td>Bacteria</td> <td>Work-shift Fatigue</td> </tr> <tr> <td>Vibration</td> <td>Dust</td> <td>Parasite</td> <td>Risk of being burned</td> </tr> <tr> <td>Electrical Shock</td> <td>Gases</td> <td>Fungus</td> <td>Repetition</td> </tr> <tr> <td>Temperature</td> <td>Fumes</td> <td>Animals</td> <td></td> </tr> <tr> <td>Repetitive Motion</td> <td>Acids</td> <td></td> <td></td> </tr> <tr> <td>Heavy Lifting</td> <td>Solvents</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Caustics</td> <td></td> <td></td> </tr> </table>	<u>Physical</u>	<u>Chemical</u>	<u>Biological</u>	<u>Psychological</u>	Noise	Mercury	Viruses	Boredom	Radiation	Lead	Bacteria	Work-shift Fatigue	Vibration	Dust	Parasite	Risk of being burned	Electrical Shock	Gases	Fungus	Repetition	Temperature	Fumes	Animals		Repetitive Motion	Acids			Heavy Lifting	Solvents				Caustics			<p>Example: Sprained back muscles due to heavy lifting (indicate left/right if applicable).</p>
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Date																																						
Last 5 Digits of SSN																																						
Company Name	Hazards:	<p>Did you suffer a work-related injury?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answer Yes, please explain:</p>																																				
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Occupational History for Firefighters – Part I: Primary Work continued

Name _____		Last 5 Digits of SSN _____
Company Name _____	Hazards:	
Job Title _____		
City _____ State _____	Comments:	
Date Started _____ Date Ended _____		
Average Hours per Week _____		
		Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Company Name _____	Hazards:	
Job Title _____		
City _____ State _____	Comments:	
Date Started _____ Date Ended _____		
Average Hours per Week _____		
		Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Company Name _____	Hazards:	
Job Title _____		
City _____ State _____	Comments:	
Date Started _____ Date Ended _____		
Average Hours per Week _____		
		Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:

Occupational History for Firefighters – Part II: Secondary Work

<u>Secondary Work</u> Examples: Firefighting Civil Defense Farming Civic Activities	List of potential hazards you were exposed to, such as: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"><u>Physical</u> Noise Radiation Vibration Electrical Shock Temperature Repetitive Motion Heavy Lifting</td> <td style="width: 25%; vertical-align: top;"><u>Chemical</u> Mercury Lead Dust Gases Fumes Acids Solvents Caustics</td> <td style="width: 25%; vertical-align: top;"><u>Biological</u> Viruses Bacteria Parasite Fungus Animals</td> <td style="width: 25%; vertical-align: top;"><u>Psychological</u> Boredom Work-shift Fatigue Risk of being burned Repetition</td> </tr> </table>	<u>Physical</u> Noise Radiation Vibration Electrical Shock Temperature Repetitive Motion Heavy Lifting	<u>Chemical</u> Mercury Lead Dust Gases Fumes Acids Solvents Caustics	<u>Biological</u> Viruses Bacteria Parasite Fungus Animals	<u>Psychological</u> Boredom Work-shift Fatigue Risk of being burned Repetition	Did you suffer a work-related illness or injury? Check Yes or No for each employment below. Please explain each Yes answer. Example: Sprained back muscles due to heavy lifting (indicate left/right if applicable).
<u>Physical</u> Noise Radiation Vibration Electrical Shock Temperature Repetitive Motion Heavy Lifting	<u>Chemical</u> Mercury Lead Dust Gases Fumes Acids Solvents Caustics	<u>Biological</u> Viruses Bacteria Parasite Fungus Animals	<u>Psychological</u> Boredom Work-shift Fatigue Risk of being burned Repetition			
<u>Part II applies to your secondary work:</u>						
_____ Company Name	Hazards:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				
_____ Job Title	Comments:	If you answer Yes, please explain:				
_____ _____ City State						
_____ _____ Date Started Date Ended						
_____ Average Hours per Week						
_____ Company Name	Hazards:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				
_____ Job Title	Comments:	If you answer Yes, please explain:				
_____ _____ City State						
_____ _____ Date Started Date Ended						
_____ Average Hours per Week						

Occupational History for Firefighters – Part II: Secondary Work continued

Name _____	Last 5 Digits of SSN _____	
Company Name _____	Hazards: Comments:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Job Title _____		
City _____ State _____		
Date Started _____ Date Ended _____		
Average Hours per Week _____		
Company Name _____	Hazards: Comments:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Job Title _____		
City _____ State _____		
Date Started _____ Date Ended _____		
Average Hours per Week _____		
Company Name _____	Hazards: Comments:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Job Title _____		
City _____ State _____		
Date Started _____ Date Ended _____		
Average Hours per Week _____		

Occupational History for Firefighters – Part III: Hobbies & Activities

<u>Hobbies & Activities</u>	List of potential hazards you were exposed to, such as:	Did you suffer a work-related illness or injury? Check Yes or No for each employment below. Please explain each Yes answer.																																				
<p>This list applies to your hobbies and other activities outside of work</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><u>Physical</u></td> <td style="width: 33%;"><u>Chemical</u></td> <td style="width: 33%;"><u>Biological</u></td> <td style="width: 33%;"><u>Psychological</u></td> </tr> <tr> <td>Noise</td> <td>Mercury</td> <td>Viruses</td> <td>Boredom</td> </tr> <tr> <td>Radiation</td> <td>Lead</td> <td>Bacteria</td> <td>Work-shift Fatigue</td> </tr> <tr> <td>Vibration</td> <td>Dust</td> <td>Parasite</td> <td>Risk of being burned</td> </tr> <tr> <td>Electrical Shock</td> <td>Gases</td> <td>Fungus</td> <td>Repetition</td> </tr> <tr> <td>Temperature</td> <td>Fumes</td> <td>Animals</td> <td></td> </tr> <tr> <td>Repetitive Motion</td> <td>Acids</td> <td></td> <td></td> </tr> <tr> <td>Heavy Lifting</td> <td>Solvents</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Caustics</td> <td></td> <td></td> </tr> </table>	<u>Physical</u>	<u>Chemical</u>	<u>Biological</u>	<u>Psychological</u>	Noise	Mercury	Viruses	Boredom	Radiation	Lead	Bacteria	Work-shift Fatigue	Vibration	Dust	Parasite	Risk of being burned	Electrical Shock	Gases	Fungus	Repetition	Temperature	Fumes	Animals		Repetitive Motion	Acids			Heavy Lifting	Solvents				Caustics			<p>Example: Sprained back muscles due to heavy lifting (indicate left/right if applicable).</p>
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<p>Hobby or Activity</p> <hr/> <p>Job Title (if applicable)</p> <hr/> <p>City (if applicable) State</p> <hr/> <p>Date Started Date Ended</p> <hr/> <p>Average Hours per Week</p>	<p>Hazards:</p> <hr/> <p>Comments:</p>	<p>Did you suffer a work-related injury?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answer Yes, please explain:</p>																																				
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Occupational History for Firefighters – Part III: Hobbies & Activities continued

Name _____	Last 5 Digits of SSN _____	
Hobby or Activity _____	Hazards:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Job Title (if applicable) _____	Comments:	
City (if applicable) _____ State _____		
Date Started _____ Date Ended _____		
Average Hours per Week _____		
Hobby or Activity _____	Hazards:	Did you suffer a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer Yes, please explain:
Job Title (if applicable) _____	Comments:	
City (if applicable) _____ State _____		
Date Started _____ Date Ended _____		
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