

# CONFIDENTIAL REPORT OF KNOWN OR SUSPECTED PESTICIDE-RELATED ILLNESS

Please provide as much information as possible. Fields marked with an asterisk\* are critical for follow-up investigations.

Patient's Last Name*		Social Security Number		Birth Date*			Ethnicity* (check one)		
<input type="text"/>		<input type="text"/>		Month	Day	Year	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
First Name*		Middle Name (or Initial)		Age		Units		Race* (check one or more)	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>			
Address: Number, Street*						Apt/Unit Number			
<input type="text"/>						<input type="text"/>			
City/Town*			State*	ZIP Code*	County*				
<input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text"/>				
Home Telephone*		Cellular Telephone*		Gender*				<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Unknown	
<input type="text"/>		<input type="text"/>		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown					
Work Telephone		Occupation							
<input type="text"/>		<input type="text"/>							

Reporting Provider - Last Name*		First Name*		Telephone Number*	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Reporting Health Care Facility*				FAX Number	
<input type="text"/>				<input type="text"/>	
Address: Number, Street			Suite Number	Submitted by*	
<input type="text"/>			<input type="text"/>	<input type="text"/>	
City		State	ZIP Code	Date Submitted*	
<input type="text"/>		<input type="text"/>	<input type="text"/>	Month	Day
				Year	

Illness Onset Date		Initial Examination Date*		List Any Pre-existing Conditions, If Known (e.g., allergies, asthma, pregnancy, etc)			
Month	Day	Year	Month	Day	Year		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Signs and Symptoms* (check all that apply)							
<b>Dermatologic</b> <input type="checkbox"/> Blistering <input type="checkbox"/> Burns <input type="checkbox"/> Edema <input type="checkbox"/> Erythema (redness) <input type="checkbox"/> Irritation/Pain <input type="checkbox"/> Pruritis (itching) <input type="checkbox"/> Rash <input type="checkbox"/> Other _____		<b>Neurologic/Sensory</b> <input type="checkbox"/> Anxiety/Irritability <input type="checkbox"/> Ataxia (incoordination) <input type="checkbox"/> Confusion <input type="checkbox"/> Depressed consciousness/Coma <input type="checkbox"/> Diaphoresis (profuse sweating) <input type="checkbox"/> Dizziness <input type="checkbox"/> Fasciculation (muscle twitching) <input type="checkbox"/> Headache <input type="checkbox"/> Muscle pain/cramping <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Salivation <input type="checkbox"/> Seizure <input type="checkbox"/> Tremors <input type="checkbox"/> Other _____		<b>Ocular</b> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Corneal abrasion <input type="checkbox"/> Irritation/Pain <input type="checkbox"/> Lacrimation (tearing) <input type="checkbox"/> Miosis (pinpoint pupils) <input type="checkbox"/> Photophobia <input type="checkbox"/> Other _____		<b>Other Systemic</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Excessive urination <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/Hyperexia <input type="checkbox"/> Malaise <input type="checkbox"/> Tachycardia <input type="checkbox"/> Other _____	
<b>Gastrointestinal</b> <input type="checkbox"/> Abdominal pain/cramping <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____		<b>Respiratory</b> <input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea (shortness of breath) <input type="checkbox"/> Rhinitis (runny nose) <input type="checkbox"/> Upper respiratory irritation/Pain <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____		<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Pesticide-related death Date of Death Month   Day   Year <input type="text"/> <input type="text"/> <input type="text"/>			

Were Diagnostic or Laboratory Tests Conducted?		Treatment Rendered*	
<input type="checkbox"/> No <input type="checkbox"/> Yes, Completed <input type="checkbox"/> Yes, Pending		<input type="text"/>	
If Completed or Pending, Please Describe:		Medical Diagnosis	
Test:		<input type="text"/>	
Results (include reporting units):		<input type="text"/>	
Normal range or baseline used:		<input type="text"/>	

Remarks (Include physician observations, or other detail relevant to the case, not provided above. Additional pages may be attached.)

Pesticide Exposure Date		Name of Pesticide(s) or Active Ingredient(s)*		<input type="checkbox"/> Unknown
Month	Day	Year		
Location Where Pesticide Exposure Occurred (please provide street address, cross streets, or other appropriate detail)*				
County of Exposure*		Describe How Patient Was Exposed to Pesticide (e.g., drift, direct spray, environmental residue, spill, ingestion)		
Did Exposure Occur at Work?*		If Yes, Name of Patient's Employer	Name of Patient's Supervisor	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Patient's Activity When Pesticide Exposure Occurred (Check one)				
<input type="checkbox"/> Mixing/loading/applying pesticide		<input type="checkbox"/> Transporting/storing/disposing of pesticide		
<input type="checkbox"/> Field work		<input type="checkbox"/> Routine indoor activity not involved with pesticide application		
<input type="checkbox"/> Flagging		<input type="checkbox"/> Routine outdoor activity not involved with pesticide application		
<input type="checkbox"/> Maintaining/repairing pesticide application equipment		<input type="checkbox"/> Emergency response		
<input type="checkbox"/> Manufacturing/formulating pesticide		<input type="checkbox"/> Other _____		
<input type="checkbox"/> Packing/processing agricultural commodities		<input type="checkbox"/> Unknown		
Were Others Exposed?		Additional Detail on Pesticide Exposure Incident		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

Reporting Agency Name*				
Street Address				Suite Number
City	State	ZIP Code	County	
Telephone Number	FAX Number	Date Reported*		Person Filing Report with State
( )	( )	Month	Day	Year

**Definition of a Pesticide Illness**

A pesticide illness case is a patient who is or may be suffering from pesticide poisoning or any disease or condition caused by a pesticide. The term **pesticide** includes any product intended to repel, kill, prevent, destroy, control, or mitigate any pest. Pesticides include insecticides, herbicides, plant growth regulators, rodenticides or other vertebrate control agents, repellents, dessicants, fungicides, miticides, disinfectants, sterilants, and sanitizers. Spray adjuvants are pesticides under California law.

**Reporting Requirement**

**Physicians** are required to report known or suspected pesticide-related illness to the **local health officer** within 24 hours (Health and Safety Code §105200). Failure to report is a citable offense and subject to civil penalty (\$250).

The **local health officer** is required to immediately notify the **county agricultural commissioner** and to file the pesticide-illness report with the following **state agencies** within 7 calendar days:

<b>Office of Environmental Health Hazard Assessment</b> Pesticide and Environmental Toxicology Branch P.O. Box 4010 Sacramento, CA 95812-4010 <b>(916) 327-7324 (Voice)</b> <b>(916) 327-7320 (Fax)</b>	<b>Department of Pesticide Regulation</b> Worker Health and Safety Branch P.O. Box 4015 Sacramento, CA 95812-4015 <b>(916) 445-4222 (Voice)</b> <b>(916) 322-8577 (Fax)</b>	<b>Department of Industrial Relations</b> Division of Labor Statistics and Research P.O. Box 420603 San Francisco, CA 94142-0603 <b>(415) 703-3020 (Voice)</b> <b>(415) 703-3029 (Fax)</b>
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**Medical Cost Reimbursements from Pesticide Drift Episodes**

Food and Agricultural Code §12997.5 requires that persons responsible for pesticide drift, which causes acute pesticide illness or injury in a non-occupational setting that requires emergency medical transport or treatment, be liable to the individual harmed or to the medical provider for the immediate costs of uncompensated medical care. The acute pesticide illness or injury must result from a pesticide use violation where the pesticide was used for agricultural commodities. For more information, visit the Department of Pesticide Regulation website at <http://www.cdpr.ca.gov/docs/county/sb391.pdf>.

**Confidential Patient Medical Information Requirements**

This document contains confidential medical information, subject to federal and state law. Submission as prescribed will not violate the Health Insurance Portability and Accountability Act of 1996, or HIPAA (Pub. L. 104-191; 45 CFR Part 160 and Part 164, Subparts A and E). Information is confidential pursuant to Cal. Const. Art. 1, §1; Gov. Code §6254(c); and Civil Code §1798 et seq.

Reporting of known or suspected pesticide illness is mandatory. Use of this exact form is not required, but it is provided for data standardization.  
**For additional forms, please visit: <http://www.oehha.ca.gov/pesticides>.**

**Thank-you for reporting a known or suspected pesticide-related illness!**

CLAIM FORM

File with:

A.G. Kawamura, Secretary  
California Department of Food and Agriculture  
1220 N Street  
Sacramento, CA 95814

Name of Claimant: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Daytime: \_\_\_\_\_ Evening \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

Type of Loss:      \_\_\_ Personal Injury \_\_\_ Other \_\_\_ Property Damage\_

When did injury or damage occur?

Where did injury or damage occur?

How did injury occur?

What action or inaction of Department employee(s) caused your injury or damage?

What injury or damage did you suffer?

Name of any witness:

Name of California Department of Food and Agriculture employee(s) involved?

State the amount claimed: Personal Injury \_\_\_\_\_ Property Damage \_\_\_\_\_ Other \_\_\_\_\_

**NOTE: Please attach copies of supporting documentation of the amounts claimed**

**ALL NOTICES AND/OR COMMUNICATION SHOULD BE SENT TO:**

Name (Mr./Mrs./Ms.) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

**Warning:** California State law generally requires that most claims against a public entity, such as the California Department of Food and Agriculture within SIX (6) MONTHS from the date of the action or incident giving rise to the claim. Certain other claims must be filed within ONE (1) YEAR from the action or incident. You should check the Government Code to determine what presentation period applies in your case.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date