Objective: To provide guidance for PREDICT personnel to prepare for and respond to field emergencies.
Table of Contents: Emergency Preparedness

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Section 3.7h Appendix VIII. United States General Services Administration Motor Vehicle Accident Report Form
Section 3.1. Overview and Resources
This material is intended to supplement other PREDICT guides and protocols that detail safety and protection measures for field situations. Namely it is imperative that all personnel are thoroughly familiar with the PREDICT guides relevant to their job tasks (e.g., PREDICT guides for Safe Animal Capture and Handling (Section 5.2.5.), Human Biological Sampling (Section 5.4.2.), Biosafety and PPE Use (Section 4.), Basic Laboratory Safety Guides (Section 6.3.), as well as the relevant sampling guides for specific taxa. This document is intended to provide guidance and a collection of materials and resources for personnel use.

In performing fieldwork in their role for PREDICT, personnel may encounter a wide variety of hazards that they should be prepared for ahead of time. These hazards and the risks associated with them will vary and depend on many factors. This guide is intended to help personnel identify and prepare for the hazards, emergencies, and accidents they are most likely to encounter and that are not otherwise well-covered in PREDICT materials. It must be understood that the risk of accidents and emergencies can never be eliminated, but that careful planning and good preparation can minimize many of the most serious risks and resulting negative outcomes.

Emergency and accident preparedness encompasses a large body of information and materials beyond the scope of this guide. Personnel seeking further information on topics relating to emergency preparedness for disasters, general building operations, laboratory procedures, and related activities are advised to seek information on what are generally referred to as ‘emergency action plans’ (EAP) or ‘accident preparedness plans’ (APP). Additional information on those topics can be found at the following links:

**Emergency Action Plans**
- [http://www.nuc.berkeley.edu/sites/default/files/resources/safety-information/Building%20Emergency%2007%20FINAL.pdf](http://www.nuc.berkeley.edu/sites/default/files/resources/safety-information/Building%20Emergency%2007%20FINAL.pdf)
- [http://www.lni.wa.gov/Safety/TrainingPrevention/Programs/?F=SHPN](http://www.lni.wa.gov/Safety/TrainingPrevention/Programs/?F=SHPN)
- [www.osha.gov/SLTC/etools/evacuation](http://www.osha.gov/SLTC/etools/evacuation)

**General Disaster Preparedness:**
- [http://www.redcross.org/prepare/disaster](http://www.redcross.org/prepare/disaster)

Section 3.2. Confirmation of Knowledge
When you are familiar with the information in this guide, take the PREDICT quiz in Section 8.4.2. Emergency Preparedness.
**Section 3.3. Plan for Field Emergencies**

Accidents and emergencies are inherently unplanned events, but many of them can be anticipated and prepared for. Being prepared for emergencies requires planning. Good planning is particularly important when working with field teams and in remote locations.

A basic process for emergency planning should include the following steps (adapted from the Global Safe Haven Network, which is targeted to individual student travel planning but has useful resources; [www.globalsafehaven.org](http://www.globalsafehaven.org)):

1. **Understand the hazards** and issues you may face. Consider the following categories of hazards: health, security, travel requirements, weather environment, transportation, legal, financial, communications, culture, language. (See following section for more information.)
2. **Evaluate the risks.**
3. **Communicate** with all field team members and supervisors to make sure everyone understands, is comfortable with, and is prepared for identified risks.
4. **Address and mitigate each issue** to your team’s comfort level. Most risk mitigation strategies have inherent financial costs. Regardless of whatever else is addressed, develop an emergency communication plan.
5. **Monitor the local situation** in the event something changes.
6. **Respond to any change** or incident as necessary by preplanning.


**Identify Hazards**

The types of hazards and emergencies that any team may encounter will depend on many variables. Some will be consistent with all field activities while others may depend on site or time specific field activities. Therefore, hazards should be identified and evaluated before each field activity, and plans should be developed appropriately.

The following list (with worksheet in Appendix I) is provided in order to assist field teams to compile appropriate lists for their specific activities and sites.

**Some Potential Field Hazards and Issues**

1. **Health**
   a. Exposure to infectious diseases not associated with the project (malaria, dengue fever, cholera, etc.)
   b. Pharmacy availability
   c. Access to emergency medical care
   d. Handled animal bite/scratch/goring
   e. Non-target animal bite/scratch/goring (including snakebite)
   f. Staff anesthetic exposure
   g. Other toxic exposure
h. PPE breach/infectious disease exposure (needlestick, scalpel cut)
i. Burn, chemical injury
j. Fall/trauma
k. Spontaneous (heart attack, appendicitis, heatstroke, hypoglycemic crisis)
l. Accidental gunshot wound

2. Security
   a. Robbery, car jacking
   b. Coup, riot, political uprising
   c. Passport lost or stolen

3. Travel requirements
   a. Insufficient visa/entry paperwork for any/all staff
   b. Improper vehicle paperwork

4. Weather and environment
   a. Extreme temperature or conditions
   b. Flood
   c. Severe storm
   d. Earthquake

5. Transportation
   a. Auto accident
   b. Vehicle breakdown
   c. Inability to refuel

6. Legal
   a. Police/military detainment (warranted or unwarranted)
   b. Insufficient permits for samples, supplies (including dart guns), chemicals

7. Financial
   a. Unexpected expenses (including bribes)
   b. Access to cash (ATMs, banks, etc.)
   c. Emergency evacuation costs

8. Communications
   a. Lack of mobile phone coverage
   b. Loss of primary communications (dead phone battery, robbery)

9. Culture
   a. Lack of local permission to perform activities
   b. Lack of cooperation (suspicion, lack of communication)

10. Language
    a. Inability to communicate with local population in event of emergency

Once hazards are identified, addressed, and discussed, field teams should reach a consensus on appropriate measures to take and plan accordingly. In addition to those measures, field teams should always prepare at least the two types of documents described below for each field site.
Prepare “Emergency Communications Plan” (template provided in Appendix II). The purpose of an Emergency Communications Plan is to make sure that field teams can access necessary resources in the event of an emergency. Critical to this planning is having a well-informed understanding of what communications will be available at the field site. In many regions mobile phone coverage may not exist and/or be limited to only certain carriers. Field teams should always have a basic or back-up plan for how to communicate if an emergency arises whether directly from a field site or by reaching the nearest resource. In many cases the team may have only one vehicle, which poses a risk if the vehicle breaks down and there is no local communication. It is recommended that each field team have a satellite phone to secure communication capacity for the field team.

Prepare “Field Personnel Emergency Information Records” (template provided in Appendix III). The purpose of Personnel Emergency Information Records is to make sure that critical information about each team member is known and readily available in case of emergency. Emergency planning should consider worst-case scenarios and in this context a team member may be unconscious or otherwise unable to communicate. The information gathered for this type of documentation may be imperative for emergency responders and other medical authorities. It should be noted that ‘emergency responders’ may not always (or even usually) be available and that those responsibilities would then fall upon other team members until medical services can be engaged.

Emergency Planning Checklist: A checklist for emergency planning is provided as Appendix IV and should be supplemented and edited as needed.

Section 3.4. First Aid
A comprehensive presentation of First Aid is beyond the scope of this document and personnel are referred to any recently published First Aid manuals, booklets, or guides. Those seeking further information may find the subcategory of First Aid referred to as “Wilderness First Aid” particularly useful because it deals with emergencies in remote settings. The Wilderness Medical Society has a number of resources, including guides and bibliographies, at their website: www.WMS.org.

Field teams should all have at least two members who are properly trained in basic First Aid techniques including cardiopulmonary resuscitation (CPR)1 and wound management.

Personnel should also always operate under the basic tenets of First Aid: preserve life, prevent further harm, and promote recovery. Field teams must also always have a First Aid Kit available (see below). It is the responsibility of the Country Coordinator to seek training for personnel and ensure field teams follow this basic premise.

1 Note: most CPR training certificates must be renewed every 12 months.
If no other resources are available, the following basic online First Aid resources can be consulted: [http://www.redcross.org](http://www.redcross.org) or [http://www.firstaidweb.com](http://www.firstaidweb.com).

While PREDICT field teams will typically be equipped with extensive medical supplies for field anesthesia of wildlife, sampling and diagnostics, they should also carry basic First Aid kits (best kept in waterproof containers) with dedicated materials for personnel emergencies.

Below is a basic First Aid kit list to which you can add on as the length and remoteness of your trip dictates:

- 10 pairs of nitrile gloves (medium and large)
- 1 CPR mask (with one-way valve)
- 4 absorbent compress dressings (5 x 9 inches)
- 25 adhesive bandages (assorted sizes)
- 1 adhesive cloth tape (10 yards x 1 inch)
- 5 antibiotic ointment packets (approximately 1 gram)
- 5 antiseptic wipe packets
- 2 packets of aspirin (81 mg each) (within the expiration date)
- 2 packets of ibuprofen (within the expiration date)
- 4 packets of anti-diarrheal tablets such as loperamide
- 1 blanket (space blanket)
- 1 instant cold compress
- 2 hydrocortisone ointment packets (approximately 1 gram each)
- 2 antibiotic ointment packets (approximately 1 gram each)
- Scissors
- 1 roller bandage or vet wrap (3 inches wide)
- 1 roller bandage or vet wrap (4 inches wide)
- 5 sterile gauze pads (3 x 3 inches)
- 5 sterile gauze pads (4 x 4 inches)
- Oral thermometer (non-mercury/non-glass)
- 2 triangular bandages
- Compression wrap for supporting ankles or knees
- Tweezers
- First aid instruction booklet
- Headlamp or other light source
- +/- EpiPen for life-threatening allergic reactions to be administered by trained personnel. A training video can be found here: [http://www.epipen.ca/en/about-epipen/how-to-use-epipen](http://www.epipen.ca/en/about-epipen/how-to-use-epipen) Print out instruction form found here and include in kit: [http://www.epipen.ca/sites/default/files/pdf/en/Instruction_Sheet.pdf](http://www.epipen.ca/sites/default/files/pdf/en/Instruction_Sheet.pdf). EpiPen users must observe the expiration date of the individual pens and replace accordingly. Expired EpiPens are considered hazardous waste and must be returned to the pharmacy where they were purchased for proper disposal.
Section 3.5. Employee Health

Personnel safety is covered in the PREDICT guides for Safe Animal Capture and Handling (Section 5.2.5.), Human Biological Sampling (Section 5.4.2.), and for Biosafety and PPE Use (Section 4.). This section supplements that information and refers specifically to practices relating to institutional occupational health and safety programs.

In the United States, the Occupational Safety and Health Administration mandates that employers “assure safe and healthful working conditions” for employees, and that medical testing is available to employees exposed to potential hazards to determine whether the health of such employees is adversely affected by such exposure” (Occupational Safety and Health Act 1970). All PREDICT partner institutions are assumed to be appropriately managing general occupational health programs for their staff both domestically and abroad.

With an understanding that institutional practices may vary, the following recommendations apply to all PREDICT field personnel:

**General Practices**

1. Individuals with known allergies associated with animals, with immune deficiency diseases, or who are on immunosuppressant therapy, should not engage in studies involving the handling of animals and sick people.
2. Pre-exposure screening for tuberculosis is required for personnel who will be handling non-human primates. Tuberculosis screening and interpretation of results should only be conducted by a human health professional.
3. If within institutional capacity and guidelines, it is advised that periodic (annual) blood/serum samples be collected from all staff and banked.
4. All accidents, injuries and medical emergencies should be recorded and reported to direct supervisors immediately (see following section and report templates in Appendices VII a, b, and c).

**Immunizations**

1. The Country Coordinator or field supervisor should ensure that personnel have consulted with a human health professional with regard to the immunizations required prior to travel or participating in fieldwork that involves handling animals, human and animal samples. Required vaccines and immunizations will vary depending on the geographical area, animal species to be handled, whether staff member will be conducting human sampling, and personal medical history. Only a human health professional can recommend and provide vaccination and immunizations to personnel.
2. Due to the significant risks of rabies exposure when working with wild mammals (bats, carnivores, etc.), pre-exposure rabies vaccination is required for all personnel handling these species.
3. Tetanus immunization is also required for all personnel.
Health Records
All personnel health records must be guarded with the strictest confidentiality as directed by institutional requirements. Templates for employee medical history and vaccinations are provided in Appendix V and VI.

Section 3.6. Incident or Accident Reporting
It is important that any on the job accident or injury requiring even basic medical attention, including self-treatment, is documented and reported. PREDICT field personnel are presumed to be operating in environments often characterized by unhygienic conditions and with many known and unknown hazards (infectious agents, animals, human samples, scalpels, needles, darts, chemicals, etc.). Not all consequences of even the most minor injuries can always be foreseen and even minor cuts or abrasions can lead to life-threatening infection with pathogenic, treatment-resistant agents, especially in remote settings. Basic information collected at the time of injury can help to identify health hazards for future preventative actions and may also be critical for future treatment, clinical interventions, or even legal proceedings.

Accident and incident reporting may be mandated by each PREDICT partner institution. In the absence of other guidelines, very basic template accident reporting forms, provided in Appendix VII, can be used as-is or edited as needed. These templates include formats for both personal injury as well as motor vehicle accidents.
Section 3.7a. Appendix I. Hazard Identification Worksheet

Field Activity: _________________________________
Date:   _________________________________
Location: _________________________________
Team Leader: _________________________________

A. Health *(e.g., animal injuries, human sampling, traumas, toxins)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________
   d. __________________________________________
   e. __________________________________________
   f. __________________________________________

B. Security *(e.g., robbery, unrest)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________

C. Travel Requirements *(e.g., visas, permits)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________

D. Weather and Environment *(e.g., storms, natural disasters)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________

E. Transportation *(e.g., auto accident, breakdown, fuel)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________

F. Legal *(e.g., detention, permits)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________

G. Financial *(e.g., extra expenses, evacuations)*
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________
H. Communications (e.g., loss of primary form of communication)
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________

I. Culture (e.g., lack of local cooperation)
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________

J. Language (e.g., inability to communicate with locals)
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________
Section 3.7b. Appendix II. Emergency Communications Plan Template

Planned Activity Date(s): ____________________________

Team Leader: Name: ____________________________ Phone: ______________

Team Members
Name: ____________________________ Phone: ______________
Name: ____________________________ Phone: ______________
Name: ____________________________ Phone: ______________
Name: ____________________________ Phone: ______________

Satellite phone number: ____________________________________________

Local or Regional Supervisor or Contact (not with team):
Name: ____________________________ Phone: ______________, ______________, ______________

International Emergency Supervisor or Contact
Name: ____________________________ Phone: ______________, ______________, ______________

Field Site:
Country: ____________________________ Region, Province, 
State: ____________________________
City/Village/Local: ____________________________
GPS Coordinates: ____________________________ Reference: ______________

EXPECTED MOBILE PHONE SERVICE: __________________________________________

Local Point(s) of Contact: Name: ____________________________
Phone: ______________ Address: ____________________________

Local Emergency Number, if any (e.g., 911 service) ____________________________

Nearest Hospital and Contact Info: ____________________________

Nearest Clinic, Dispensary and Contact: ____________________________

Nearest Airport: ____________________________

Nearest Phone Line: ____________________________

Local Police: ____________________________ National Police: ____________________________

Other Emergency Contacts (fire, ambulance): ____________________________

Local Authority (mayor, district supervisor, district authority):
__________________________________________

Legal Contact or Lawyer: ____________________________

Embassy, Consulate Mission Contacts: ____________________________
Section 3.7c. Appendix III. Field Team Emergency Information Template

<table>
<thead>
<tr>
<th>Name</th>
<th>Date &amp; place of birth</th>
<th>Passport info (Country, #)</th>
<th>Personal/family emergency contact information</th>
<th>Health insurance (provider, policy, primary physician)</th>
<th>Med-evac insurance (provider, policy)</th>
<th>Blood type</th>
<th>Medical conditions</th>
<th>Known allergies</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

v.28Nov2016
Section 3.7d. Appendix IV. Emergency Checklist for PREDICT Field Activities

___ Copy of emergency contact list/communications plan to accompany team (originals should be stored in office files).

___ Copy of field team personnel info data to accompany team

___ Copies of above documents accessible in office and/or with emergency contacts

___ First aid kit

___ Primary communications equipment (cell phone, sat phone, two-way radio)

___ Back-up communications equipment

___ Vehicle emergency equipment (spare tires, triangles, fire extinguisher, extra food and water, etc)

___ Printed current maps of field location and surrounding areas

___ GPS unit

___ Emergency funds

  • Local cash
  • ‘Hard’ currency (dollars, Euros, pounds sterling)
  • Internationally accepted credit cards

___ Original and/or photocopies of passports, permits, and insurance cards

___ Spare batteries, car/DC charger adapter

___ Flashlights

___ Emergency kits for expected procedures (e.g., Ebola or B virus exposure kits)
## Section 3.7e. Appendix V. Adult Vaccine Record

### CDC Format

**Vaccine Administration Record for Adults**

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient’s personal record card.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Type of Vaccine</th>
<th>Date given (month/year)</th>
<th>Funding source (FS/LP)</th>
<th>Route &amp; Site</th>
<th>Vaccine</th>
<th>Vaccine Information Statement (VIS)</th>
<th>Vaccinator* (signature or initials &amp; date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis (Td, Tdap)</td>
<td>Give IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>(e.g., HepA, Hep A-BeHep)</td>
<td>Give IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>(e.g., HepB, Hep A-BeHep)</td>
<td>Give IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV2, HPV4)</td>
<td>Give IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>CMV (live SC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VVAR)</td>
<td>Give SC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>(e.g., PCV10 conjugate, PCV13, pneumococcal)</td>
<td>Give IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>(e.g., MenACWY conjugate, MenB polysaccharide)</td>
<td>Give Meningitis IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See page 2 to record influenza, Hib, zoster, and other vaccines (e.g., travel vaccines).

### How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see Table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and Title.
6. For combination vaccines, fill in a row for each antigen in the combination.

---

*Abbreviation and Trade Name/Manufacturer:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Trade Name/Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Td</td>
<td>Adult diphtheria-pertussis vaccine (DTP)</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus vaccine (HPV)</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Meningococcal meningitis vaccine (MenB)</td>
</tr>
<tr>
<td>PCV13</td>
<td>Pneumococcal conjugate vaccine (PCV13)</td>
</tr>
<tr>
<td>MenACWY</td>
<td>Meningococcal conjugate vaccine (MenACWY)</td>
</tr>
<tr>
<td>MenB</td>
<td>Meningococcal conjugate vaccine (MenB)</td>
</tr>
<tr>
<td>MenB polysaccharide</td>
<td>MenB polysaccharide vaccine (MenB polysaccharide)</td>
</tr>
</tbody>
</table>

---

This form was created by the Immunization Action Coalition - www.immunize.org - www.usaidinformation.org
**Vaccine Administration Record for Adults**

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Type of Vaccine</th>
<th>Date given</th>
<th>Funding Source</th>
<th>Route &amp; Site</th>
<th>Vaccine</th>
<th>Vaccine Information Statement (VIS)</th>
<th>Vaccinator (age, sex, or initials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Various</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>DTwP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster (Zostavax)</td>
<td>SC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

See page 1 to record Td/TTd, hepatitis A, hepatitis B, HPV, MMN, varicella, pneumococcal, and meningococcal vaccines.

**How to Complete This Record**

1. Record the generic abbreviation (e.g., Td) or the trade name for each vaccine (see Table at right).
2. Record the funding source of the vaccine given as either Federal, State, or Private.
3. Record the route by which the vaccine was given as either Intramuscular (IM), Subcutaneous (SC), Intradermal (ID), Intranasal (IN), or Oral (PO) and also the site where it was administered as either LA (left arm), RA (right arm), LA (left thigh), or LT (right thigh).
4. Record the date the dose of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
Section 3.7f. Appendix VI. USAID Medical History and Examination Form

| Bureau for Economic Growth, Agriculture And Trade |
| Office of Education |
| MEDICAL HISTORY AND EXAMINATION FOR FOREIGN APPLICANTS (Medical History To Be Completed By Applicant) |

<table>
<thead>
<tr>
<th>1. LAST NAME – FIRST NAME – MIDDLE NAME</th>
<th>2. DATE OF BIRTH (MONTH/DATE/YEAR)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. NATIONALITY</th>
<th>4. SEX</th>
<th>Female</th>
</tr>
</thead>
</table>

| 6. TRAINING LOCATION (City, State for U.S. training) | 7. LENGTH OF TRAINING (Weeks, Months, Years) | 8. ESTIMATED DATE TO BEGIN TRAINING (Month/Year) |

**IMPORTANT NOTICE**
Before You Complete The Medical History Questionnaire, You Are Herby Notified That:
- USAID does not provide medical insurance for dependents that accompany persons on the applicant.
- A medical condition resulting from an undisclosed pre-existing condition will not be covered by the USAID HAC insurance and may result in termination of your training program. Likewise, a medical condition resulting from a previously undiagnosed condition may not be covered by the USAID HAC insurance and may become the responsibility of the applicant. Your training program may be terminated if it is determined that your condition will significantly impact your program, or if you cannot cover the cost of the medical care. Public funds may not be used to cover the cost of medical care.
- I understand that by accepting USAID sponsorship I hereby waive any privacy rights that I have to such medical claims and agree to permit my insurance provider or its authorized representatives to release all information related to such claims to USAID. Such notification will include the date of the claim, the nature of the claim and copies of all documentation related to the claim. USAID shall use such claim information for reviewing its entire insurance program. I understand that I have the right to revoke this authorization by providing written notice to USAID. Such revocation will result in automatic termination of USAID’s sponsorship of the program, unless USAID otherwise agrees in writing.

6. I understand and accept the terms of this notice. Yes No

10. CHECK EACH ITEM YES OR NO; EVERY ITEM CHECKED “YES” MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have you ever had any significant or serious illness or injury? (Include dates)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Have you had any surgery or been advised by a physician to have surgery? (Give place &amp; date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Do you currently use any drugs for treatment of a medical condition? (Give name &amp; dose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Have you ever been a patient in a mental hospital or sanitarium or treated by a Psychiatrist? (Give place &amp; date)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. DO YOU NOW HAVE, OR HAVE YOU EVER HAD THE CONDITIONS LISTED BELOW? (Indicate “Yes” or “No.” To Each Item)

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Epilepsy or convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Eye disease, vision defect in both or either eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Tooth or gum disease (periodontal disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Asthma, emphysema, or other lung conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Tuberculosis or lime with anyone who has tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. High blood pressure, heart diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Stomach, liver (hepatitis), gallbladder disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Menstrual (cystitis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Kidney or bladder disease, stone or block in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Diabetes in the urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Joint disease or injury, swollen or painful joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Back pain, wear a back brace or support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Tropical disease malaria, bilharzias, amoebiasis, leprosy, filariasis, yaws, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Depression, excess worry, attempted suicide, or other psychological symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Bleeding disorder, blood disease (sickle cell anemia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Acquired Immune Deficiency Syndrome (AIDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Tumor, abnormal growth, cyst, or cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. Skin disorder, growths, psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t. Female disorder, growths, psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>u. Pregnancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

12. PRINTED NAME OF APPLICANT: 
13. DATE: 
14. SIGNATURE OF APPLICANT:

NOTE: For the Examinor: Please review this Medical History and make appropriate remarks on the Physician’s Examination Form for any boxes checked yes. Any additional tests must be indicated on the Examination Form. Any test results that indicate a pre-existing condition(s) must be noted and explained.
REPORT OF MEDICAL EXAM FOR FOREIGN APPLICANTS
(To Be Completed By The Examining Physician)

15. NAME OF PARTICIPANT

16. HEIGHT
17. WEIGHT
18. BLOOD PRESSURE
19. CORRECTED VISION

20. URINALYSIS (Sugar, blood, etc.)

21. BLOOD SEROLOGY TEST FOR SYPHILIS
   (optional)
   - Positive
   - Negative

22. CHEST X-RAY REPORT (Date)

23. PREGNANCY TEST (HCG) (optional)
   - Positive
   - Negative

24. ELECTROCARDIOGRAM REPORT (if indicated by history or physical)

25. CLINICAL EVALUATION: (EVERY ITEM CHECKED "ABNORMAL" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT)

   NORMAL
   - Head, Nose, Mouth
   - Ears, Hearing Acuity
   - Lungs and Chest
   - Heart, Rhythm & Sounds
   - Vascular System, Varicosities
   - Abdomen, Hernia, etc.
   - Hemorrhoids, Fistula Prostate
   - Urinary System
   - Spine, Arms, Legs, etc.
   - Skin, Lymph Nodes, Scars
   - Neurological
   - Emotional Stability

   ABNORMAL
   - Describe abnormal findings

26. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED "YES" IN THE HISTORY AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION. ADDITIONAL TESTS MUST BE IDENTIFIED. ANY TEST THAT INDICATES A PRE-EXISTING CONDITION(S) MUST BE DOCUMENTED AND BROUGHT TO THE ATTENTION OF THE USAID APPROVING OFFICER.

27. SUMMARY OF ANY DEFECTS AND DIAGNOSIS

28. NAME AND ADDRESS OF EXAMINING PHYSICIAN (Please Print or Type)

29. SIGNATURE OF EXAMINING PHYSICIAN

30. DATE OF EXAMINATION

AID 1382-1 (1/2010)
# ADMINISTRATIVE REVIEW OF MEDICAL EXAMINATION
(For Use By Post Training Office)

1. **NAME OF CANDIDATE:** (Last, First, Middle)

## MEDICAL CLEARANCE ACTION

**ACTION BY SPONSORING UNIT OR DESIGNEE**

- [ ] Recommend Approval of Applicant’s Entry into Training Program
- [ ] Recommend Disapproval of Applicant’s Entry into Training Program

- [ ] Recommend waiver of Applicant’s medical ineligibility for the following reasons. Health cost liability for pre-existing medical conditions will be assumed by the [Mission or Bureau]. (USAID signature located at bottom of this page)

- [ ] Health cost liability for pre-existing medical conditions will be assumed by the responsible party noted below.

## REASON FOR REJECTION / WAIVER OF INELIGIBILITY

**SIGNATURE**

**PRINTED NAME**

**DATE**

**REVIEWED BY:**

**SIGNATURE**

**PRINTED NAME**

## MISSION/BUREAU MEDICAL WAIVER ACTION

Applicants rejected for training because of medical problems may be re-evaluated for training with a waiver of HAC coverage for specified pre-existing condition.

The USAID Mission/Bureau may determine to grant a waiver when:

1. It is felt that the period of training will be of short duration and medical condition is unlikely to be activated or aggravated during that period; or
2. The training is considered essential to the program objective.

By granting this waiver request, the USAID Mission/Bureau accepts full responsibility to ensure payment of all claims arising from waived conditions. This determination by the USAID Director or U.S. officer designee must be obtained prior to further processing of the applicant.

**Waived Condition(s):**

**SIGNATURE**

**DATE**

**PRINTED NAME**

**POSITION TITLE**

---

**AID 1382-1 (1/2010)**

Page 3 of 3
Section 3.7g. Appendix VII. OSHA Form for Injury and Illness Report

**Version A**

### OSHA Form 301- Injury and Illness Incident Report

#### Information about the injured person

1. Full name: ____________________________
2. Street: ____________________________
3. City: State Zip: ____________________________
4. Date of birth: ___________ Date hired: ___________
5. Male ☐ Female ☐
6. Employee ☐ Contractor ☐
7. High School Days: Work: ☐
8. Student ☐ Visitor ☐
9. Employee # __________

#### Information about the injury or illness

10. Extent of treatment: None ☐ First Aid ☐ Medical Treatment ☐
11. If treatment was given away from the workplace, where was it given?
   - Dr. Name: ____________________________
   - Facility: ____________________________
   - Street: ____________________________
   - City: State Zip: ____________________________
12. Was the injured person treated in an emergency room?
   - Yes ☐ No ☐
13. Was the injured person hospitalized overnight as an inpatient?
   - Yes ☐ No ☐

#### Information about the case

14. Date of injury or illness: ___________
15. Time of event: AM ☐ PM ☐ Unknown ☐
16. Time injured person began work: ___________ AM ☐ PM ☐
17. Date lost from work: ___________ to ___________
18. Date on restricted duty: ___________ to ___________

#### Completed by: ____________________________
   - Title: ____________________________
   - Phone: ____________________________
   - Date: ____________________________

---

Attention: This form contains information relating to injured persons' health and must be used in a manner that protects the confidentiality of the information while being used for occupational safety and health purposes to the extent possible.

Complete this form for all injuries and illnesses. When complete, print this form, get necessary signatures, & make two photocopies. Forward the original to the IHIS Coordinator in 11253.

Visit the website for a complete guide. For the incident, tell the story. The affected person keeps the remaining photocopy. This form should be completed within 24 hours of the incident.

www.nondesa.ca.gov/ihis/injury/accidentreport.pdf

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v.28Nov2016

PREDICT Operating Procedures: Emergency Preparedness - 20
# Section 3.7h. Appendix VIII. United States General Services Administration

## Motor Vehicle Accident Report Form

### MOTIVE VEHICLE ACCIDENT REPORT

Please read the Privacy Act Statement on Page 5

**INSTRUCTIONS:** Sections I through IX are filled out by the vehicle operator. Section X, Items T2 thru T2c are filled out by the operator's supervisor. Section XI thru XIII are filled out by an accident investigator for bodily injury, fatality and/or damage exceeding $500.

### SECTION I - FEDERAL VEHICLE DATA

1. **DRIVER’S NAME (Last, first, middle)**
2. **DRIVER’S LICENSE NO./STATE LIMITATIONS**
3. **DATE OF ACCIDENT**
4a. **DEPARTMENT/FEDERAL AGENCY PERMANENT OFFICE ADDRESS**
4b. **WORK TELEPHONE NUMBER**
5. **TAX OR IDENTIFICATION NUMBER**
6. **EST. REPAIR COST $**
7. **YEAR OF VEHICLE**
8. **MAKE**
9. **MODEL**
10. **SEAT BELTS USED**
    a. **YES**
    b. **NO**
11. **DESCRIBE VEHICLE DAMAGE**

### SECTION II - OTHER VEHICLE DATA (Use Section VIII if additional space is needed)

12. **DRIVER’S NAME (Last, first, middle)**
13. **SOCIAL SECURITY NO./TAX IDENTIFICATION NO.**
14. **DRIVER’S LICENSE NO./STATE LIMITATIONS**
15. **DRIVER’S HOME ADDRESS**
16a. **WORK TELEPHONE NUMBER**
16b. **HOME TELEPHONE NUMBER**
17. **DESCRIPTION OF VEHICLE DAMAGE**
18. **ESTIMATED REPAIR COST $**
19. **YEAR OF VEHICLE**
20. **MAKE OF VEHICLE**
21. **MODEL OF VEHICLE**
22. **TAG NUMBER AND STATE**
23. **DRIVER’S INSURANCE COMPANY NAME AND ADDRESS**
23a. **OWNER’S NAME(s) (Last, first, middle)**
23b. **POLICY NUMBER**
23c. **TELEPHONE NUMBER**
24. **VEHICLE IS**
    a. **PRIVATELY OWNED**
    b. **RENTAL**
    c. **CO-OWNED**
    d. **LEASED**
25. **OWNERS’ ADDRESSES**

### SECTION III - KILLED OR INJURED (Use Section VIII if additional space is needed)

26. **NAME (Last, first, middle)**
27. **SEX**
28. **DATE OF BIRTH**
29. **ADDRESS**
30. **MARK “X” IN TWO APPROPRIATE BOXES**
    a. KILLED
    b. DRIVER
    c. PASSENGER
    d. INJURED
    e. HELPER
    f. PEDESTRIAN
    g. OTHER (2)
31. **TRANSPORTED BY**
32. **TRANSPORTED TO**
33. **NAME (Last, first, middle)**
34. **SEX**
35. **DATE OF BIRTH**
36. **ADDRESS**
37. **MARK “X” IN TWO APPROPRIATE BOXES**
    a. KILLED
    b. DRIVER
    c. PASSENGER
    d. INJURED
    e. HELPER
    f. PEDESTRIAN
    g. OTHER (2)
38. **TRANSPORTED BY**
39. **TRANSPORTED TO**
40. **NAME (Last, first, middle)**
41. **SEX**
42. **DATE OF BIRTH**

### Additional Information

- **NAME OF STREET OR HIGHWAY**
- **DIRECTION OF PEDESTRIAN**
  - FROM__
  - TO__
- **DESCRIBE WHAT PEDESTRIAN WAS DOING AT TIME OF ACCIDENT**
  - crossing intersection with signal, against signal, diagonally, in roadway playing
  - walking, hitchhiking, etc.

**STANDARD FORM 91 (2000)**
Prescribed by GSA-FM 102-34.286

v.28Nov2016
### SECTION IV - ACCIDENT TIME AND LOCATION (Use section VII if additional space is needed.)

<table>
<thead>
<tr>
<th>48. DATE OF ACCIDENT</th>
<th>49. PLACE OF ACCIDENT (street address, city, state, ZIP Code; Nearest landmark; Distance nearest intersection; Kind of locality (industrial, business, residential, open country, etc.); Road description).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>50. TIME OF ACCIDENT</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM</td>
<td>PM</td>
</tr>
</tbody>
</table>

51. INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED

52. POINT OF IMPACT (Check one for each vehicle)

<table>
<thead>
<tr>
<th>FED</th>
<th>2</th>
<th>AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>Front</td>
</tr>
<tr>
<td></td>
<td>b</td>
<td>R. Front</td>
</tr>
<tr>
<td></td>
<td>c</td>
<td>L. Front</td>
</tr>
<tr>
<td></td>
<td>d</td>
<td>Rear</td>
</tr>
<tr>
<td></td>
<td>e</td>
<td>R. Rear</td>
</tr>
<tr>
<td></td>
<td>f</td>
<td>L. Rear</td>
</tr>
<tr>
<td></td>
<td>g</td>
<td>R. Side</td>
</tr>
<tr>
<td></td>
<td>h</td>
<td>L. Side</td>
</tr>
</tbody>
</table>

53. DESCRIBE WHAT HAPPENED (Refer to vehicles as "FED", "2", "3", etc. Please include information on posted speed limit, approximate speed of vehicles, road conditions, weather conditions, weather conditions, driver visibility, condition of accident vehicles, traffic controls (warning light, stop light, etc.), condition of light (daylight, dusk, night, dawn, artificial light, etc.), and driver actions (making a U-turn, passing, stopped in traffic, etc.)

### SECTION V - WITNESS/PASSENGER (Witness must fill out SF 94, Statement of Witness) (Continue in Section VIII.)

A

<table>
<thead>
<tr>
<th>54. NAME (Last, first, middle)</th>
<th>55. WORK TELEPHONE NUMBER</th>
<th>56. HOME TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B

<table>
<thead>
<tr>
<th>57. WORK ADDRESS</th>
<th>58. HOME ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>59. NAME (Last, first, middle)</th>
<th>60. WORK TELEPHONE NUMBER</th>
<th>61. HOME TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>62. WORK ADDRESS</th>
<th>63. HOME ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION VI - PROPERTY DAMAGE (Use Section VIII if additional space is needed.)

<table>
<thead>
<tr>
<th>64a. NAME OF OWNER (Last, first, middle)</th>
<th>64b. WORK TELEPHONE NUMBER</th>
<th>64c. HOME TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>64d. WORK ADDRESS</th>
<th>64e. HOME ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>65a. NAME OF INSURANCE COMPANY</th>
<th>65b. TELEPHONE NUMBER</th>
<th>65c. POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>66. ITEM DAMAGED</th>
<th>67. LOCATION OF DAMAGED ITEM</th>
<th>68. ESTIMATED COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION VII - POLICE INFORMATION

<table>
<thead>
<tr>
<th>69a. NAME OF POLICE OFFICER</th>
<th>69b. BADGE NUMBER</th>
<th>69c. TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>70. PRECINCT OR HEADQUARTERS</th>
<th>71a. PERSON CHARGED WITH ACCIDENT</th>
<th>71b. VIOLATION(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STANDARD FORM 91 (2/2004) PAGE 2
### SECTION VIII - EXTRA DETAILS

Space for detailed answers. Indicate section and item number for each answer. If more space is needed, continue items on plain bond paper.

---

### PRIVACY ACT STATEMENT

The information on this form is subject to the Privacy Act of 1974 (5 U.S.C. section 552a). Authority to collect the information is Title 40 U.S.C. Section 481 and the title 31 U.S.C. Section 7701. The formation is required by federal Government agencies to administer motor vehicle programs, including maintaining records on accidents involving privately owned and Federal fleet vehicles, and collecting accident claims resulting from accidents. Federal employees, and employees under contract, will use the information only in the performance of their official duties. Routine uses of the collected information may include disclosures to: appropriate Federal, State, or local agencies or contractors when relevant to civil, criminal, or regulatory investigations or prosecutions; the Office of Personnel Management and the General Accounting Office for program evaluation purposes; a Member of Congress or staff in response to a request for assistance by the individual of record; another Federal agency, including the Department of Treasury and Justice, or a court under judicial proceedings; agency Inspectors General in conducting audits; private insurance and the collection agencies (including agencies under contract to Treasury to collect debt); and to other agency finance offices for federal management and debt collection. Furnishing the requested information is mandatory, including the Social security Number or Taxpayer’s Identification Number (TIN) for use as a unique identifier to ensure accurate identification for individuals or firms in the system.

---

### SECTION IX - FEDERAL DRIVER CERTIFICATION

<table>
<thead>
<tr>
<th>72a. NAME AND TITLE OF DRIVER</th>
<th>73b. DRIVER’S SIGNATURE AND DATE</th>
</tr>
</thead>
</table>

---

### SECTION X - DETAILS OF TRIP DURING WHICH ACCIDENT OCCURRED

<table>
<thead>
<tr>
<th>75. ORIGIN</th>
<th>76. DESTINATION</th>
</tr>
</thead>
</table>

---

### 76. TRIP BEGAN

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME (Include AM or PM)</th>
<th>77. ACCIDENT OCCURRED</th>
<th>DATE</th>
<th>TIME (Include AM or PM)</th>
</tr>
</thead>
</table>

---

### 78. AUTHORITY FOR THE TRIP WAS GIVEN TO THE OPERATOR

- [ ] ORALLY
- [ ] IN WRITING (Explain)

### 79. WAS THERE ANY DEVIATION FROM DIRECT ROUTE?

- [ ] NO
- [ ] YES (Explain)

---

### 80. WAS THE TRIP MADE WITHIN ESTABLISHED WORKING HOURS?

- [ ] YES
- [ ] NO (Explain)

### 81. DID THE OPERATOR, WHILE ENROUTE, ENGAGE IN ANY ACTIVITY OTHER THAN THAT FOR WHICH THE TRIP WAS AUTHORIZED?

- [ ] NO
- [ ] YES (Explain)

---

### 82. COMPLETED BY DRIVER’S SUPERVISOR

<table>
<thead>
<tr>
<th>a. DID THIS ACCIDENT OCCUR WITHIN THE EMPLOYEE’S SCOPE OF DUTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] YES</td>
</tr>
</tbody>
</table>

### 83a. NAME AND TITLE OF SUPERVISOR

### 83b. SUPERVISOR’S SIGNATURE AND DATE

### 83c. TELEPHONE NUMBER

---

STANDARD FORM 91 (2/2004) PAGE 3
### SECTION XI - ACCIDENT INVESTIGATION DATA

84. DID THE INVESTIGATION DISCLOSE CONFLICTING INFORMATION: 
- [ ] NO
- [ ] YES (If checked, explain below.)

### 85. PERSONS INTERVIEWED

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
<th>NAME</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

86. ADDITIONAL COMMENTS (Indicate section and item number of each comment):

### SECTION XII - ATTACHMENTS

87. LIST ALL ATTACHMENTS TO THIS REPORT

### SECTION XIII - COMMENTS/APPROVALS

88. REVIEWING OFFICIAL'S COMMENTS

<table>
<thead>
<tr>
<th>89. ACCIDENT INVESTIGATOR</th>
<th>90. ACCIDENT REVIEWING OFFICIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. SIGNATURE</td>
<td>a. SIGNATURE</td>
</tr>
<tr>
<td>b. DATE</td>
<td>b. DATE</td>
</tr>
<tr>
<td>c. NAME (First, middle, last)</td>
<td>c. NAME (First, middle, last)</td>
</tr>
<tr>
<td>d. TITLE</td>
<td>d. TITLE</td>
</tr>
<tr>
<td>e. OFFICE</td>
<td>e. OFFICE</td>
</tr>
<tr>
<td>f. OFFICE TELEPHONE NUMBER</td>
<td>f. OFFICE TELEPHONE NUMBER</td>
</tr>
<tr>
<td>AREA CODE</td>
<td>NUMBER</td>
</tr>
</tbody>
</table>

STANDARD FORM 91 (3/2004) PAGE 4