

Participant ID: _____

For NIOSH use only

Date _____ Start time _____ End time _____

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State of Residence _____

Form Approved
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Exp. Date 3/31/2013

PAULSBORO RESPONDER SURVEY

RESPONSE SECTION

We would like to learn more about your experience during the Paulsboro train derailment response. From now on we will refer to the derailment and resulting vinyl chloride release on November 30, 2012 as “the incident.”

1. Were you a firefighter, police officer, or other professional who responded to the incident?
 - Firefighter
 - Police officer
 - EMS responder
 - Hospital emergency department worker
 - Other (Please specify): _____

2. What specifically was your role during the response?

3. The incident occurred on Friday 11/30/2012 at approximately 7:00am. What date and time did you first arrive on scene?

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4. Approximately how many total hours did you work in an area that was evacuated at some point following the incident?

5. What initial information did you receive about the incident prior to your arrival on scene?

6. Did you know there was a chemical release and which chemical was released when you arrived on scene?

Yes No Unsure

7. Did you smell an odor? If no or unsure skip to question 10.

Yes No Unsure

8. Can you please describe the odor?

9. Would you describe the odor as light, moderate or severe?

Light Moderate Severe

10. Did you experience an unusual taste in your mouth? If no or unsure skip to question 12.

Yes No Unsure

11. Can you please describe the taste?

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12. Were you in a cloud of fog while you were there?

Yes No Unsure

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

Yes
 No →

14. How were you decontaminated? Please check all that apply.

Clothing Removal
 Water
 Soap and Water
 Other (Please specify): _____

15. Where were you decontaminated? This question is asking for a geographic location, not a place on your body.

16. Have you had any of the following injuries related to this incident?

Injury	Yes	No
Fall	<input type="checkbox"/>	<input type="checkbox"/>
Motor vehicle accident	<input type="checkbox"/>	<input type="checkbox"/>
Burn	<input type="checkbox"/>	<input type="checkbox"/>
Laceration/puncture	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Assault	<input type="checkbox"/>	<input type="checkbox"/>
Animal bite/sting	<input type="checkbox"/>	<input type="checkbox"/>
Sprain/Strain	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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17. Is there anything else you want to tell us related to the incident?

ACUTE HEALTH EFFECTS SECTION

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

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

Yes

No →

19. Please fill out the table below about symptoms that could be related to the vinyl choloride that was released.

	i. Did you experience [Symptom] within 24-hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u>		ii. Were you experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u>		iii. Was your [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u>		iv. Are you still experiencing [Symptom]? <u>Repeat i for next symptom.</u>	
Symptom	Yes	No	Yes	No	Yes	No	Yes	No
a. Irritation/pain/ burning of eyes								
b. Headache								

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	i. Did you experience [Symptom] within 24-hours of the incident? <u>If yes, go to ii. If no, repeat i for next symptom.</u>		ii. Were you experiencing [Symptom] before the incident? <u>If yes, go to iii. If no, go to iv.</u>		iii. Was your [Symptom] worse after the incident? <u>Continue to iv (if listed); otherwise, repeat i for next symptom.</u>		iv. Are you still experiencing [Symptom]? <u>Repeat i for next symptom.</u>	
Symptom	Yes	No	Yes	No	Yes	No	Yes	No
c. Dizziness or lightheadedness								
d. Confusion								
e. Sleepiness								
f. Loss of balance								
g. Generalized weakness								
h. Nausea								
i. Vomiting								
j. Ringing of the ears								
k. Runny nose								
l. Burning nose or throat								
m. Burning lungs								
n. Difficulty breathing/ feeling out-of-breath								
o. Coughing								
p. Increased congestion or phlegm								
q. Chest tightness								
r. Wheezing in chest								
s. Irritation, pain, or burning of skin								
Any other symptoms? <u>If yes, What were they? Record below.</u>								
t.								
u.								

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MEDICAL CARE

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

- Yes →
- No

21. Why didn't you seek medical care? (Check all that apply)

- 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 _____

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

- Yes
- No →

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

____/____/____
MM DD YYYY

24. Were you provided with care at a hospital?

- Yes
- No →

25. 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 you 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

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

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

Treated in emergency department (Outpatient) →

Admitted (Hospitalized)

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

_____ Nights

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

Yes

No →

30. Read i-iv and record information in the table below.

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

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

Yes

No →

31. What is the name of the medicine or medicines you were prescribed? If you do not know the name of the medication, what is the medication used for?

32. Please tell me if any of the following describe why you sought medical care. Read questions a-c and circle the appropriate answer(s).

a. You were given instructions to seek medical care?

Yes No Unsure

b. You experienced health problems or symptoms within 24 hours of the incident?

Yes No Unsure

c. You were worried about possible health problems associated with the incident?

Yes No Unsure

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MEDICAL HISTORY

Now we're going to ask you a few questions about illnesses you may have had and the kinds of medicines you may have used.

33. 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 specify as directed.

Medical Condition	
a. Allergies, hay fever, or eczema?	Yes (Please specify) _____ No Unsure
b. Asthma?	Yes No Unsure
c. Diabetes?	Yes No Unsure
d. High blood pressure?	Yes No Unsure
e. Chronic bronchitis, chronic obstructive pulmonary disease (COPD) or emphysema?	Yes No Unsure
f. Heart Disease?	Yes No Unsure

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Medical Condition	
g. Physical disability that hinders mobility?	Yes (Please specify) _____ No Unsure
h. Depression or mood disorder?	Yes No Unsure
i. Anxiety, disorder?	Yes No Unsure
j. Cancer?	Yes (Please specify) _____ No Unsure
k. Posttraumatic stress disorder	Yes No Unsure
l. Immune disorders such as lupus, rheumatoid arthritis, or HIV?	Yes No Unsure
m. Neurological conditions such as Parkinson's disease or multiple sclerosis?	Yes No Unsure
n. Skin condition?	Yes (Please specify) _____ No Unsure

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34. 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

No →

35. What medicines were you taking? If you do not know the name of the medication, what was the medicine for?

36. Prior to the incident, were you taking any medications for the treatment of tuberculosis, such as Isoniazid, Rifampin, or Pyrazinamide?

Yes

No

Don't know

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

Yes →

No

38. Have you smoked regularly in the past?

Yes

No →

39. When did you last quit? Was it...

Less than one year ago

1–2 years ago

3–4 years ago

5 or more years ago

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40. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage?

Days per week

Days per month

Don't know

41. Are you currently pregnant?

Yes

No

Don't Know

42. Are you currently breastfeeding?

Yes

No

OCCUPATIONAL HEALTH SECTION

Now we're going to ask you some questions about your work experiences—paid, volunteer, or military—from 12/12/2011 to 12/12/2012. 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.

43. Are you currently employed?

Yes →

No

44. Did you have a job in the last 12 months, that is, since 12/12/2011?

Yes

No

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45. If you had more than one job in the last 12 months, please tell us 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 the next job.

	Job 1	Job 2
a. What (is/was) the name of the company you (work/worked) for?		
b. What (does/did) this company make or do?		
c. What do you do for a living?		
d. (Does/Did) this job include working with or around any chemicals? <u>If no or unsure, go to f.</u>	Yes No Unsure	Yes No Unsure
e. <u>If yes</u> , what chemicals (do/did) you work with or around?		

46. Have you taken any days off due to health problems related to the incident?

Yes

No

47. What training have you received? (check all that apply)

First responder awareness

Annual refresher

First responder operations (8 hr)

Annual refresher

Hazardous materials technician (24 hr)

Annual refresher

HAZWOPER (24 hr)

Annual refresher

HAZWOPER (40 hr+)

Annual refresher

Other training, describe: _____

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48. Please look at this list and tell me what level of PPE you were wearing when you responded to the incident.

- 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 other please specify the type of protection:

49. Did you wear a respirator?

- Yes
- No
- Don't know

50. If yes, what type of respirator did you wear? (e.g., disposable mask, half face reusable, full face, PAPR, SCBA)

51. Did you go through "fit testing" to make sure your respirator fit correctly?

- Yes
- No
- Don't know

52. Did you receive training about how and when to properly use the respirator you wore?

- Yes
- No
- Don't know

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53. If you did not wear a respirator, what were the reasons you did not wear it?

Please check all that apply.

- It wasn't required for the work I did
- None was available
- They didn't have my size
- Mine was damaged and I couldn't get a replacement
- It got in the way of doing my work
- It was too hot or uncomfortable
- I didn't know how to wear it or use it
- I didn't think I needed it
- It got too dirty
- I forgot to wear it
- I thought wearing it made me less safe
- Other (please specify) _____
- Don't know

Please indicate whether you strongly agree, agree, disagree, or strongly disagree with the following two statements that might or might not describe your response job.

54. There were no significant shortcuts or compromises taken when worker safety was at stake.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Don't know

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55. I had the training I needed/need to perform my job safely and competently.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Don't know

The following questions ask about general knowledge and training. For each question, please circle the response that best describes your organization, overall.

56. Safety issues are given a high priority in training programs

All of the time	Most of the time	Some of the time	A little of the time	None of the time
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

57. Workplace health and safety training covers the types of situations that employees encounter in their job

All of the time	Most of the time	Some of the time	A little of the time	None of the time
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

58. Employees receive comprehensive training in workplace health and safety issues

All of the time	Most of the time	Some of the time	A little of the time	None of the time
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

59. Employees have sufficient access to workplace health and safety training programs

All of the time	Most of the time	Some of the time	A little of the time	None of the time
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

60. I know how to perform my job in a safe manner

All of the time	Most of the time	Some of the time	A little of the time	None of the time
------------------------	-------------------------	-------------------------	-----------------------------	-------------------------

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61. I know how to use safety equipment and standard work procedures

All of the time	Most of the time	Some of the time	A little of the time	None of the time
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62. I know how to maintain or improve workplace health and safety

All of the time	Most of the time	Some of the time	A little of the time	None of the time
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MENTAL HEALTH SECTION

63. The following questions ask about how you have been feeling since the incident. For each question, please circle the number that best describes how often you had this feeling.

	Since the incident, about how often did you feel ...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	nervous?	1	2	3	4	5
b.	hopeless?	1	2	3	4	5
c.	restless or fidgety?	1	2	3	4	5
	Since the incident, about how often did you feel ...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
d.	that everything was an effort?	1	2	3	4	5
e.	worthless?	1	2	3	4	5

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64. The last set of questions asked about feelings that might have occurred since the incident. Taking them all together, did these feelings occur **more often** since the incident than is usual for you, **about the same** as usual, or **less often** than usual? Please circle the number that best describes how you have been feeling.

More often than usual			About the same as usual	Less often than usual		
A lot	Some	A little		A little	Some	A lot
1	2	3	4	5	6	7

COMMUNICATION SECTION

65. Does your agency have interagency communications with other first responders?

- Yes
- No
- Don't know

66. Do mobile patrols have interagency communication?

- Yes
- No
- Don't know

67. Does your dispatch center have radio interagency communication?

- Yes
- No
- Don't know

68. How would you rate your current state of interagency communications with other first responders on a scale of 1 to 10 (10 being the highest)?

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When your agency is the Incident Commander (IC):

69. How does your IC request first responders from other agencies to the incident site?

70. How does your IC and first responders from other agencies communicate to the incident site?

When another agency is the Incident Commander (IC):

71. How does the IC (from another agency) request first responders from your agency to the incident site?

72. How do your first responders and the IC communicate on the incident site?

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DEMOGRAPHIC INFORMATION

Now, I have some general questions about you.

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

- Yes
- No
- Don't Know

74. 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
- Other (Please specify): _____

75. 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

76. Are you male or female?

- Male
- Female

77. How tall are you?

Height _____ ft _____ in

78. How much do you weigh?

Weight _____ lbs

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The next three pages will be separated from the rest of the questionnaire and securely held at the New Jersey Department of Health if follow-up is necessary:

1. What is your name?

2. What is your date of birth?

____/____/____
MM DD YYYY

3. What is your current address?

Street _____ Apt _____

City _____ State __ __ Zip Code: _____

4. 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

Participant ID: _____

5. Are there any more telephone numbers where you can be reached? If yes, list all other numbers and specify whether cell, house, or work number.

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

- Cell
 House
 Work

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

- Cell
 House
 Work

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

- Yes
 No

What is your email address?

7. We may want to survey 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
 No

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	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)			

That completes this survey. We would like to sincerely thank you for your time.