

3e. Pesticide illness & injury

Health care providers in Santa Cruz County must notify the County Agricultural Commissioner when they encounter any significant illness or injury caused by pesticides.

Why the Ag Commissioner?

The Agricultural Commissioner has been deputized by the County Health Officer to receive and act on reports of people hurt by agricultural chemicals on the farm, at home, or on the roadside.

Upon receipt of your timely report, the Commissioner will immediately investigate and take action to prevent further damage from the exposure. That's good for both public health and environmental health.

In all cases, phone within 1 working day

 (831) 763-8080

if you diagnose or suspect significant illness or injury caused by pesticides.

Do not mail or fax your Pesticide Illness Report

Make the phonecall. A representative from the Ag Commissioner will come and take your report in person.

What do I do if exposure occurred in a neighboring county?

Contact the County Health Officer in that county:

Monterey County (831) 759-7325

Santa Clara County (408) 918-4600

San Mateo County (650) 363-4700

San Benito County (831) 637-534

For occupational incidents within Santa Cruz County

In addition to the immediate pesticide illness phonecall, complete a *Doctor's First Report of Occupational Injury or Illness* form when the incident is occupational.

Mail or fax it within 1 week to:



Ag Commissioner
 175 Westridge Drive
 Watsonville, CA 95076



(831) 763-8255 fax

Not First Aid

Treatment for pesticide related illness or injury is not considered first aid, and is therefore reportable under Worker's Comp laws.

Failure to report pesticide related illnesses is punishable by a fine of \$250 for each unreported case.

Thumbnail of Pesticide Illness Report on the next page. Use this State form to report illness or injury caused by pesticides.



State of California Environmental Protection Agency (CalEPA)		Office of Environmental Health Hazard Assessment	
PESTICIDE ILLNESS REPORT (For illnesses caused by pesticides—including sanitizers and disinfectants)			
PATIENT:			
Name:	Age:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:	City:	County:	
Phone No.:	Social Security Number:	Occupation:	
Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other
PHYSICIAN FILING REPORT:			
Physician's name:			
Physician's address:			
INJURY:			
At Address:	<input type="checkbox"/> At Home	<input type="checkbox"/> At Work—agriculture	City:
At work:	<input type="checkbox"/> At Work—nonagriculture	<input type="checkbox"/> Other exposure	County:
a) Employer's name:			
Employer's address:			
b) Manager or Supervisor:			
Date of exposure:	/ /	Time of exposure:	: : a.m. [] p.m.
Date of onset:	/ /	Date of death:	/ /
Is there reason to believe others were exposed? <input type="checkbox"/> No <input type="checkbox"/> Yes			
PATIENT'S DESCRIPTION OF EXPOSURE:			
Activity at time of exposure:			
<input type="checkbox"/> Applying pesticides <input type="checkbox"/> Manufacturing pesticides <input type="checkbox"/> Mixing pesticides <input type="checkbox"/> Entering pesticide areas			
<input type="checkbox"/> Transfer of pesticides or tree contents <input type="checkbox"/> Using contaminated food			
<input type="checkbox"/> Other exposure (explain):			
Name of pesticide(s):		Ingredient(s) of pesticide(s):	
Primary route of exposure: <input type="checkbox"/> Oral <input type="checkbox"/> Dermal <input type="checkbox"/> Eye <input type="checkbox"/> Inhalation <input type="checkbox"/> Unknown			
PHYSICIAN'S DESCRIPTION OF EXPOSURE:			
Date first seen: / /			
Time first seen: :			
Major signs, symptoms, adverse reactions:			
Hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, hospital name: _____ City: _____			
Emergency room only? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Physician's office only? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Diagnostic studies ordered? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, which studies? _____			
Diagnosis: _____			
Treatment: _____			
Brief description of incident (if female, indicate if pregnant): _____			
AGENCY COMPLETING FORM:			
Agency/County:		By whom:	
Address:			
Phone no:			
Form OEHPS 004 (Rev. 5/96) (P1, P19, 2/00)			