POST–DEPLOYMENT ASSESSMENT

Thank you for deploying. The Florida Department of Health (FDOH) wants to ensure you experienced a safe and healthy work environment during your deployment. Your safety is paramount; therefore, we ask that you please complete this Post-Deployment Assessment at the end of your deployment to inform us of your experience. Use additional sheets if necessary to respond to questions on the form.

During your deployment, you may receive handouts regarding illnesses that may have occurred in persons that have worked at your deployment site. Please read and familiarize yourself with this material to help alert you to health complaints (injury, illness, and mental health) that may require further evaluation.

What to watch for in the weeks following deployment: As a Responder or relief worker, you may encounter extremely stressful situations, such as witnessing loss of life, injuries, separated families, and destruction. These experiences may cause psychological or emotional difficulties. Up to one-third of workers will experience depression shortly after returning home. A mental health professional can help you with psychological or emotional difficulties. If you or your family is suffering from behavioral, psychological, or emotional problems contact the Employee Assistance Program at (800) 860-2058. The Employee Assistance Program (EAP) is always available to you and your family at no cost. Participating in the EAP will in no way jeopardize your job security. All information is strictly confidential and independent of personnel or other public records. **Internalizing stressors only enhances the chances of stress becoming an illness.**

ASSESSMENT

Deployment Dates: From:____________________ To: ________________________________

What were your duties during deployment? (Please check all that apply)

☐ Search, Rescue
☐ Safety/Health
☐ Medical/Healthcare
☐ Law Enforcement/Security
☐ Facilities Assessment
☐ Operations
☐ Recovery
☐ Peer Support/Critical Incident Stress Management
☐ Immigration Enforcement
☐ Other ____

Worksite (Please check all boxes that apply):

Deployment sites: ____

____

Daily travel time to work site (if applicable): _________

Hrs/Day_____ Days/Week _____ Weeks/Month___________ Total Months __________

Shift Work: (check one): ☐ 8 hours ☐ 12 hours ☐ 16 hours

☐ Other(explain): ____
Total hours per week (worked):____________________
Rest Periods: _______________ Average hours sleep per day/night: _____________________
Was sleep/rest period uninterrupted? ☐ **YES** ☐ **NO**

Known hazardous exposures or conditions
Type of exposure or conditions (if known) ____
Work practices ____

Protective measures used by Responders to protect themselves from dangers of any kind
☐ Respiratory Protection-type ____________
☐ Respiratory Protection - Fit Tested Mask
☐ Eye Protection _____________
☐ Hearing Protection _____________
☐ Gloves _____________
☐ Protective Suit _____________ (apron, shroud, boots et.al.)
☐ Other: ____

Did you have adequate training on safety and health issues relating to your work? ☐ **YES** ☐ **NO**
What were the most positive aspects of this deployment for you? ________________________
____
____

What were the most difficult aspects of this deployment for you? ________________________
____
____

Do you have any suggestions for things your organization could do differently for future deployments? ____
____

Do you have any concerns about your own well-being as you leave? _____________________
____
____

Injuries: Injuries sustained or illness symptoms experienced during response/recovery work.
Description of injury: ____
____
Complete resolution ☐ **YES** ☐ **NO** vs. Still present: ☐ **YES** ☐ **NO**

Health complaints
Current health complaints: ____
____
Are these new complaints ☐ **YES** ☐ **NO** vs. Exacerbation of preexisting condition ☐ **YES** ☐ **NO**
Do you require immediate health evaluation referral? ☐ **YES** ☐ **NO**

Note: In a medical emergency, go to the nearest medical facility or call 911 for emergency assistance. Call your Team Leader as soon as possible to relay what happened and where you are or where you are going for treatment. Following emergency medical treatment, have your Team Leader assist you in calling the approved FDOH Worker's Compensation vendor and report the incident to the servicing workers' compensation coordinator.

For non-emergency medical treatment, have your Team Leader assist you in calling the approved FDOH Worker's Compensation vendor to report the injury prior to obtaining medical treatment.

Health Considerations (Things to tell your health provider)

☐ If you are experiencing symptoms such as fever, flu-like illness, chills, headache, joint/muscle aches
☐ If you were injured or have wounds that are not healing well
☐ If you feel depressed, confused, have trouble sleeping or have a hard time adjusting back to your home environment
☐ If you were bitten or scratched by an animal
☐ If you were bitten by an insect and are having an extended or unusual reaction
☐ If you believe you were exposed to hazards such as dust, pathogens, or chemicals and continue to have persistent health problems

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL	RESPIRATORY	GENITOURINARY	NEUROLOGICAL
☐ Fatigue	☐ Chronic Cough	☐ Vaginal Discharge	☐ Loss of Bowel Control
☐ Fever	☐ Decreased Exercise Tolerance	☐ Menstrual Irregularities	☐ Dizziness/Vertigo
☐ Weight Gain >10 pounds	☐ Difficulty Breathing	☐ Difficulty Starting/ Stopping Urinary Stream	☐ Headaches
☐ Weight Loss >10 pounds	☐ Coughing Up Blood	☐ Painful Urination	☐ Numbness/Tingling
	☐ Sputum Production	☐ Change in Urinary Stream	☐ Passing Out
	☐ Wheezing	☐ Increased Frequency	☐ Seizures
		☐ Blood in Urine	☐ Tremor
		☐ Loss of Bladder Control	
		☐ Nighttime Urination	
		☐ Urinary Retention	
		☐ Urethral Discharge	
		☐ Impotence	
		☐ Penile Lesions	
		☐ Testicular Mass	
		☐ Testicular Pain	

SKIN	BREAST	Hearing, Eyes, Ears, Nose and Throat	CARDIOVASCULAR
☐ Nail Changes	☐ Breast Mass	☐ Double Vision	☐ Chest Pain
☐ New Lesions	☐ Breast Pain	☐ Eye Pain	☐ Leg Pains with Walking
☐ Rash	☐ Nipple Discharge	☐ Eye Redness	☐ Leg Swelling
☐ Skin Color Changes	☐ Skin Changes	☐ Decreased Hearing	☐ Night Awakening due to trouble breathing
		☐ Earache	☐ Palpitations
		☐ Ear Ringing	☐ Shortness of Breath
		☐ Nose Bleeds	
		☐ Dry Mouth	
		☐ Hoarseness	
		☐ Oral Ulcers	
		☐ Sore Throat	
NECK	**GASTROINTESTINAL**	**MUSCULOSKELETAL**	**PSYCHIATRIC**
☐ Neck Pain	☐ Abdominal Pain	☐ Decreased Range of Motion	☐ Anxiety
☐ Swollen Glands	☐ Change in Bowel Habits	☐ Joint Pain	☐ Change in Sleep Pattern
	☐ Constipation	☐ Joint Redness	☐ Depression
	☐ Diarrhea	☐ Joint Swelling	☐ Hallucinations
	☐ Nausea	☐ Joint Stiffness	☐ Suicidal Thoughts
	☐ Vomiting	☐ Muscle Wasting	
	☐ Rectal Bleeding	☐ Muscle Weakness	
	☐ Trouble Swallowing	☐ Muscle Aches/Pains	
HEMATOLOGY	**ENDOCRINE**		
☐ Enlarged Lymph Nodes	☐ Appetite Changes	☐ Hair Changes	
☐ Prolonged Bleeding	☐ Cold Intolerance	☐ Sexual Dysfunction	
	☐ Increased Thirst		
	☐ Increased Urination		

If you experience symptoms or conditions discussed in this document or have other concerning symptoms not listed, please see your doctor as soon as possible.

If you have any other comments or concerns, please explain here:________________________

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I have thoroughly reviewed this post-deployment assessment form and have discussed any concerns with the Safety Officer.

______________________________ ______________________________
Employee's Signature Date

______________________________ ______________________________
Team Leader Signature Date

Please submit this form to the team leader on scene, the Responder Management Unit (StateESF8.LogSTAFFING@flhealth.gov) and keep a copy for your records.