



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. We ask that you complete this Post-Deployment Assessment to inform us of your experience. Use additional sheets if necessary to respond to questions on the form.

ASSESSMENT

Deployment Dates: From: _____ To: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Search, Rescue | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Safety/Health | <input type="checkbox"/> Recovery |
| <input type="checkbox"/> Medical/Healthcare | <input type="checkbox"/> Peer Support/Critical Incident Stress Management |
| <input type="checkbox"/> Law Enforcement/Security | <input type="checkbox"/> Immigration Enforcement |
| <input type="checkbox"/> Facilities Assessment | <input type="checkbox"/> Other _____ |

Worksite:

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 of sleep per day/night: _____

Was sleep/rest period uninterrupted? YES NO

Hazardous exposures or conditions

Type of exposure or conditions (if known) _____

Location: _____

Protective measures used by responder

- Powered Air Purifying Respirator (PAPR)
- Fit Tested Mask
- Eye Protection
- Hearing Protection
- Gloves
- Personal Protective Equipment (PPE)
- 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 due to this deployment? _____

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

Health Considerations (Speak to your health provider if you are experiencing any of the following)

- Fever, flu-like illness, chills, headache, joint/muscle aches
- Injury or wounds that are not healing well
- Depression, confusion, or trouble sleeping
- Hard time adjusting back to your home environment
- Bites or scratched by an animal
- Bites from an insect that are causing an extended or unusual reaction
- Exposure to hazards such as dust, pathogens, or chemicals
- Continuous and persistent health problems related to deployment

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

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

Employee's Signature

Date

Please submit this form to the Resource/Demobilization Unit at StateESF8.Demobilization@flhealth.gov and keep a copy for your records.