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)

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