Office of the
Agricultural Commissioner
P.O. Box 1089
Riverside, CA 92502-1089
Phone 951-955-3000
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IF YOU HAVE BEEN EXPOSED TO A PESTICIDE, PLEASE CALL 911

PESTICIDE INCIDENT OR ILLNESS COMPLAINT

Date/Time: _____ Received By: _____ Complaint #_____
(YYYYMMDD-Your Initials-#)

(*For Office Use Only*)

Complainant (Can be Anonymous)

Name: _____

Address: _____

City: _____   Zip: _____

Phone: Work □_____   Home □_____   Cell □_____

Email: _____

Complaint / Incident Information:

Date/Time: _____   Location: _____

Description of what happened: _____

_____

_____

_____

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_____

Was it: □ Indoors   □ Outdoors

If it was indoors, was it: □ At Home   □ At School   □ At Work   □ Other (please specify)

_____

_____

If it was outdoors, was it: □ In your yard   □ On your street   □ Along a road   □ In a park

□ At a school playground   □ In an agricultural field   □ Other

_____

_____

How far away were you?

_____

_____

_____

What did you see? Describe what happened. *For example, did you see a pesticide application nearby? Was there a spill or a leak? Was the pesticide being sprayed? Being mixed? Transported?*

_____

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If you saw it, describe the equipment being used to apply the pesticide

□ A tractor. Was the tractor spraying?   □ Up   □ Down

□ A hand-held or back pack sprayer   □ A helicopter □ Other_____

Did you see any dust or particles?   □ Yes   □ No

Describe the weather:

Wind:	**Wind direction from the:**	**Skies:**
☐ No wind	☐ North	☐ Clear
☐ Light breeze	☐ South	☐ Cloudy
☐ Medium wind	☐ East	☐ Foggy
☐ Strong wind	☐ West	☐ Raining/drizzling
☐ Gusty wind	☐ From direction of this landmark: _____	

What were the effects you experienced?

_____

_____

_____

Did you smell or taste anything unusual? If so, describe it as best as you can. *Try to associate the odor with something familiar, like rotten eggs, sweet or sour chemical, garlic, chlorine, etc.*

_____

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Did you feel anything on your skin, eyes, or clothing? ☐ No   ☐ Yes

Did you inhale fumes? ☐ No   ☐ Yes

Was anyone injured? ☐ No   ☐ Yes

If yes, when did they start feeling sick?

_____

_____

_____

_____

_____

What were their symptoms?

_____

_____

_____

_____

_____

What part of the body was effected?

_____

_____

_____

_____

How long did the symptoms last?

_____

_____

_____

Did the injured person(s) go to the doctor or hospital? *If so, please list the name of the doctor or hospital, phone number and address, if you have it.*

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