

Exposure Information

Is your well contaminated? Have you seen a color change in the water or ever smelled offensive odors or chemical smells in your water?
(If so, describe, dates, duration)

Has your well been turned off because of contamination? If so when? Are you being provided bottled water?

Have you ever had any symptoms of lightheadedness, dizziness, trouble breathing, lethargy or any other type of symptoms that could be related to exposure to dangerous chemicals?
(If so, describe, dates, duration)

Did you seek medical attention for the symptoms? (If yes, diagnosis)

If yes, please provide the following information.

Name of Physician

Date(s) Seen

Address

(_____) _____

Phone

Name of Physician

Date(s) Seen

Address

(_____) _____

Phone

Name of Physician

Date(s) Seen

Address

(_____) _____

Phone

