

Turn Up the Heat on Burns at Work: A Survey for Teens

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Your name: _____
First name Last Name

Today's Date: ____ / ____ / 20__

Your telephone number: (____) _____

According to our review of medical records, you had a heat or chemical burn injury at work in the last 6 months.

Were you under 18 at the time of your work-related burn?

- YES
 NO
 N/A, I was not burned at work.

If YES, please continue. If NO or N/A, you do not need to fill out this questionnaire, but please return it to us in the enclosed envelope.

-
- When were you burned at work? _____
(month/year)
 - What is the name and address of the company or organization you were you working for when you were burned?
Employer _____
Street name _____ City _____ State _____
 - Which of the following best describes what kind of company or organization this is?

<input type="checkbox"/> Coffee shop / Bakery	<input type="checkbox"/> Hospital
<input type="checkbox"/> Fast food restaurant	<input type="checkbox"/> Nursing home
<input type="checkbox"/> Other restaurant	<input type="checkbox"/> Gas station
<input type="checkbox"/> Grocery store	<input type="checkbox"/> Auto Body Shop
<input type="checkbox"/> Hotel / Motel	<input type="checkbox"/> Other: _____
 - At the time of your injury, which of the following best describes your primary job at work? (**Check one**).

<input type="checkbox"/> Cashier / Clerk / Counter Help	<input type="checkbox"/> Cleaning
<input type="checkbox"/> Cook / Food Prep	<input type="checkbox"/> Dietary Aide
<input type="checkbox"/> Waiter or Waitress	<input type="checkbox"/> Repairs / Maintenance
<input type="checkbox"/> Dishwasher	<input type="checkbox"/> Other: _____
 - How old were you at the time you were burned?

<input type="checkbox"/> under 13
<input type="checkbox"/> 13
<input type="checkbox"/> 14
<input type="checkbox"/> 15
<input type="checkbox"/> 16
<input type="checkbox"/> 17

11. At the time of your burn, where was your supervisor or someone else responsible for supervising you?
- In the immediate area (in view of injury)
 - On-site
 - Not on-site
 - N/A
 - Don't know
12. Have other workers experienced similar injuries at this workplace?
- Yes
 - No
 - Don't know
13. Do you think your burn could have been prevented in some way?
- Yes (How? _____)
 - No
 - Don't know
14. Before you were burned, had you ever received any **general** instructions from your employer or supervisor on how to work safely and avoid injury?
- Yes
 - No (*Go to Question 15*)
 - Don't know / Not sure
- 14a. If YES, how were you instructed? (*check all that apply*).
- | | |
|---|--|
| <input type="checkbox"/> Through a video | <input type="checkbox"/> Co-worker showed you while working |
| <input type="checkbox"/> Through a training class/lecture | <input type="checkbox"/> Supervisor showed you while working |
| <input type="checkbox"/> Through written materials | <input type="checkbox"/> Don't remember |
15. Had you ever received any instruction from your employer or supervisor **specifically** on working safely and avoiding injury while doing the type of work or using the piece of equipment that led to your burn?
- Yes
 - No (*Go to Question 16*)
 - Don't know / Not sure
- 15a. If YES, how were you instructed? (*check all that apply*).
- | | |
|---|--|
| <input type="checkbox"/> Through a video | <input type="checkbox"/> Co-worker showed you while working |
| <input type="checkbox"/> Through a training class/lecture | <input type="checkbox"/> Supervisor showed you while working |
| <input type="checkbox"/> Through written materials | <input type="checkbox"/> Don't remember |
16. Where did you receive medical care or treatment for your burn? (*check all that apply*).
- Did not receive treatment (*Go to Question 17*).
 - First aid at workplace
 - Hospital ER (Which hospital? _____)
 - Doctor's office / Clinic / Health center (Number of visits _____)
 - Other, please specify (*e.g., physical therapy, occupational therapy, acupuncture*) _____
-
17. How many days did you miss, cut down, or not do any of your usual activities due to your burn? These activities may include school, work, recreation, extracurricular activities, or any other things you usually did.
- Number of days: _____

18. Specifically, how many days of school and work did you miss because of your injury?

School: ___ None
___ Fewer than 5 days
___ 5 days or more
How many days? _____

Work: ___ None
___ Fewer than 5 days
___ 5 days or more
How many days? _____

19. As of today, do you still have any pain, stiffness, discomfort, or other symptoms related to your injury?

___ Yes, please explain: _____
___ No
___ Don't know

20. What permanent effects do you think you may have from this burn? (*check all that apply*).

___ None
___ Scarring
___ Limited movement
___ Limited feeling or sensation
___ Pain or discomfort
___ Other, please specify: _____
___ Don't know

21. Did you, your parents, or your employer file a claim for workers' compensation?

___ Yes
___ No
___ Don't know

22. What is your date of birth? _____
month/day/year

23. Are you male or female?

___ M
___ F

24. What is your race? You may select one or more of the following categories:

___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White
___ Other / Mixed, please specify: _____

25. Are you of Hispanic or Latino origin?

___ Yes
___ No
___ Don't know

26. Do you have any other comments you would like to make about your injury, your employer, or anything else related to working teens or burns in the workplace?

Thank you for completing this interview.