

Chemical/Biological Sample Documentation

For use of this form, see FM-3; the proponent agency is TRADOC

INSTRUCTIONS

Place the biological sample inside a refrigerator, ice chest, or insulated container; and keep it as cool as possible at all times.

Sample Identification Number: _____

Date and Time Sample Collected: _____

Reason for Collection (check those that apply):

- | | |
|---|---|
| <input type="checkbox"/> Chem/Bio Attack | <input type="checkbox"/> Chem/Bio Alarm Activated |
| <input type="checkbox"/> Positive M256 Chemical Detection | <input type="checkbox"/> Positive Recon Team Findings |
| <input type="checkbox"/> Soldiers Becoming Sick | <input type="checkbox"/> Soldiers Dying |
| <input type="checkbox"/> Other _____ | |

Location of Attack _____
(UTM or place)

Date and Time of Attack _____

Unit Identification _____
(Co, Bn, Bde, Div, Corps)

Terrain Description (check those that apply):

- | | | | | | |
|--------------------------------|---------------------------------|--|--------------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Flat | <input type="checkbox"/> Hills | <input type="checkbox"/> Mountains | <input type="checkbox"/> Desert | <input type="checkbox"/> Jungle | <input type="checkbox"/> Forest |
| <input type="checkbox"/> Urban | <input type="checkbox"/> Grassy | <input type="checkbox"/> Sparse Trees/Shrubs | <input type="checkbox"/> Other _____ | | |

Weather (check those that apply):

- | | | | | | | |
|--------------------------------------|---------------------------------|-------------------------------|------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Clear | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Rain | <input type="checkbox"/> Fog | <input type="checkbox"/> Snow | <input type="checkbox"/> Dust | <input type="checkbox"/> Mist |
| <input type="checkbox"/> Other _____ | | | | | | |

Wind at Collection Site (check only one):

- | | | | |
|------------------------------------|--------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> None/Calm | <input type="checkbox"/> Mild Breeze | <input type="checkbox"/> Windy | <input type="checkbox"/> Gusts |
|------------------------------------|--------------------------------------|--------------------------------|--------------------------------|

Odor (check those that apply):

- | | | | | | |
|-----------------------------------|--------------------------------------|---------------------------------|-------------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sweet | <input type="checkbox"/> Fruity | <input type="checkbox"/> Irritating | <input type="checkbox"/> Pepper | <input type="checkbox"/> Flower |
| <input type="checkbox"/> Changing | <input type="checkbox"/> Other _____ | | | | |

Symptoms (check those that apply):

- | | | | |
|------------------------------------|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Skin Swelling | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Nausea | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Dark Skin Blotches | <input type="checkbox"/> Unconscious | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Bleeding Sores | <input type="checkbox"/> Other _____ | |

Symptoms:

Time of Onset: _____

Duration (of Symptoms): _____

Delivery Method (check those that apply):

- Unknown Artillery Mortar RPG/Grenade Rocket
 Aircraft Aerosol Generator Other _____

State of Agent at Time of Collection (check only one):

- Liquid Vapor Powder Solid Smoke Mist
 Dust (cloud) Gel Other _____

Description of Sample (check only one):

- Vegetation Soil Other _____
Biomedical: Urine Blood Tissue

Color of Sample _____

Size of Sample _____

Other _____

Additional Remarks: