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EXPOSURE CONTROL INCIDENT REPORT

This report is to be completed by the employee in the event the employee is exposed or thinks he/she may have been exposed to any bodily fluid. This report must be completed and submitted to the employee's supervisor immediately following the exposure incident.

1. Name of Individual Exposed: _____

2. Job Title: _____ **3. Date of Exposure:** _____

4. Time of Exposure: _____ **5. Location of Exposure (Room, Playground):** _____

6. Name of Source Individual: (if known) _____

7. Task being performed at the time of exposure: _____

8. Describe the Exposure Incident: _____

_____

_____

9. Type of Exposure Incident: (Check all that apply)

Puncture of Skin _____ **Contact with non-intact skin** _____

Contact w/ Mucous Membrane _____ **Other (Please specify):** _____

10. Type of Potentially Infectious Fluid: (Check all that apply)

Blood _____ **Urine** _____ **Feces** _____ **Vomit** _____

Saliva (possibly containing blood) _____ **Unknown** _____

11. Personal Protective Equipment in use during Exposure: (Check all that apply)

Gloves _____ **Gown** _____ **Other (specify)** _____

12. Clean up measures used after exposure occurred: (Check all that apply)

Exposed Area washed with soap and water ____

Disinfected Contaminated Area (specify cleaning agent) _____

Disposed of Contaminated Materials _____ **Removed Contaminated Clothes** _____

Reported Incident to Supervisor _____ **Other (specify)** _____

13. Name of Agency: _____ **Agency Phone #:** _____

Address of Agency: _____

Employee's Signature: _____ **Date:** _____

Employer's Signature: _____ **Date:** _____

EXPOSURE CONTROL CONSENT FORM

I, _____, having been informed of the risks the exposure incident poses to my health and well being, **do not consent** to have my blood drawn by a medical professional. I have been informed that there would be no cost to me, but still deny consent to draw my blood.

Employee Signature:_____ Date:_____

I, _____, having been informed of the risks the exposure incident poses to my health and well being, **consent** to having my blood drawn by a medical professional, at no cost to myself.

Employee Signature:_____ Date:_____

I, _____ having consented to have my blood drawn by a medical professional, wish at this time for my blood **not to be tested for HIV**. I understand that my employer is required to retain my blood for 90 days in the event I would change my mind and wish within the next 90 days to have my blood tested for HIV, at no cost to myself.

Employee Signature:_____ Date:_____

I, _____, having consented to have my blood drawn by a medical professional, wish at this time for my blood to be tested for HIV. I understand that the result of the test will be confidential and the results disclosed only to me. My employer will not be notified of the HIV test results.

Employee Signature:_____ Date:_____

I, _____, having been exposed to blood or other potentially infectious materials, putting me at risk for acquiring Hepatitis B virus (HBV), wish to receive a Hepatitis B vaccination series, at no cost to myself.

Employee Signature:_____ Date:_____

DECLINATION STATEMENT

I, _____ understand that due to my occupational exposure to blood or other potentially infectious materials that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline this vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B virus, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature:_____ Date:_____

POST EXPOSURE REFERRAL TO MEDICAL CONSULTANT

The following employee has been referred to you as a result of exposure to blood or other potentially infectious material. Included with this form is a copy of 29 CFR Part 1910.1030 (OSHA's Occupational Exposure to Blood borne Pathogens), Employee's Consent Form, results of the source individual's blood testing if available; and all medical records relevant to the employee's appropriate treatment. Please complete and return the attached *Report of Medical Consultant*. Please complete a medical evaluation and follow-up in accordance with the OSHA Standard.
(**NOTE:** This form is to be completed by the employer based on the information given in the EXPOSURE CONTROL INCIDENT REPORT)

1. **Name of Individual Exposed:** _____
2. **Name of Agency:** _____ **Agency Phone #:** _____

   Agency Address: _____
3. **Type of Exposure Incident: (Check all that apply)**

   Puncture of Skin _____ **Contact with non-intact skin** _____

   Contact w/ Mucous Membrane _____ **Other (Please specify):** _____
4. **Task being performed at the time of exposure:** _____
5. **Type of Potentially Infectious Fluid: (Check all that apply)**

   Blood _____ **Urine** _____ **Feces** _____ **Vomit** _____

   Saliva (possibly containing blood) _____ **Unknown** _____
6. **Brief description of the Exposure Incident:** _____

   _____
7. **Source Individual (identified to the best of the agency's ability and as allowed by law):**

   _____
8. **Has the Source Individual consented to a blood test to determine HBV and/or HIV infectivity?**

   YES _____ **NO** _____ **Not Applicable** _____

   Results of the Source Individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure if the identity and infectious status of the Source Individual.
9. **Employee's Hepatitis B Series Vaccination Dates (if applicable)**

   1st Dose _____ **2nd Dose** _____ **3rd Dose** _____

Name of Person Completing this Form: _____

Title: _____

Signature of Person Completing Form: _____ **Date:** _____

REPORT OF EVALUATION BY MEDICAL CONSULTANT

Please **DO NOT** include any information other than what is specifically requested in this form. It is a violation of the referred employee's Right of Privacy and of Doctor/Patient Privilege if additional information is provided.

1. **Name of Individual being Evaluated:** _____
2. **Name of Referring Agency:** _____
3. **Is a Hepatitis B vaccination indicated for this employee? YES_____ NO_____**
4. **The following doses of Hepatitis B Vaccine have been administered:**

   1st Dose _____ 2nd Dose _____ 3rd Dose _____
5. **Has the employee been informed of the results of this evaluation?**

   YES_____Date:_____ NO_____
6. **Has the employee been informed of any medical conditions that may result from exposure to blood or other potentially infectious materials, which require further evaluation or treatment?**

   YES_____Date:_____ NO_____

7. **Date Medical Evaluation was completed:** _____
8. **Name of Medical Consultant:** _____

   Address: _____

   Phone #: _____

Signature of Medical Consultant: _____ **Date:** _____

Please return this form to the following address- Thank you!

_____

_____

_____

A copy of this evaluation must be presented to the evaluated employee within 15 days of the completion of the evaluation. Prompt return of this evaluation by the Medical Consultant to the referring agency is appreciated.

This Report of Evaluation by a medical consultant was presented to the evaluated employee by:

Signature of Employer: _____ **Date:** _____

Signature of Employee: _____ **Date:** _____