Accident / Incident Investigation Plan – Form 2: Bloodborne Pathogens Incident Report

Instructions: This report must be completed by the employee's supervisor or manager for any exposure as defined in the Plan. A copy of this completed form must be given to the exposed employee to give to his/her healthcare provider.

A copy of this completed form must be sent to Risk Services at DC 2nd Floor

Name of Exposed Person: _____

Position of Exposed Person: _____

Date of Exposure: _____ **Date of Report:** _____

Circumstances of Exposure: _____

_____

_____

Route of Exposure: (Choose One: eye, nose, mouth, bite, skin puncture, or describe other).

_____

_____

Source Individual's Name (if known): _____

Consent obtained to test source individual's blood? **Yes** _____ **No** _____

Other pertinent information: _____

_____

Has the Hepatitis B Vaccine full series been given? **Yes** _____ **No** _____

If No: 1st vaccine date: _____ **2nd vaccine date:** _____

Has the OR-OSHA Standard been given to employee or his/her healthcare provider?

Yes _____ **No** _____

Exposed Person DECLINES Medical Follow-up Attention

_____ _____

Exposed Person's Signature **Date of Declination**

Exposed Person ACCEPTS Medical Follow-up Attention

_____ _____

Exposed Person's Signature **Date of Acceptance**