## EXPOSURE INCIDENT REPORT

**ROUTES AND CIRCUMSTANCES OF EXPOSURE INCIDENT**

***Please Print***

EMPLOYEE’S NAME

SOCIAL SECURITY NO DATE

HOME PHONE BUSINESS PHONE

DATE OF BIRTH JOB TITLE

EMPLOYEE VACCINATION STATUS

DATE OF EXPOSURE TIME OF EXPOSURE 🞎AM 🞎PM

LOCATION OF INCIDENT

NATURE OF INCIDENT (AUTO ACCIDENT, TRAUMA, MEDICAL EMERGENCY) - BE SPECIFIC, ATTACH ADDITIONAL PAGE(S) IF NECESSARY:

DESCRIBE WHAT TASK(S) YOU WERE PERFORMING WHEN THE EXPOSURE OCCURRED - BE SPECIFIC:

WERE YOU WEARING PERSONAL PROTECTIVE EQUIPMENT (PPE)? YES NO

 IF YES, LIST

DID THE PERSONAL PROTECTION EQUIPMENT FAIL? 🞎YES 🞎NO

IF YES, EXPLAIN HOW DID THE EQUIPMENT FAIL?:

WHAT BODY FLUID(S) WERE YOU EXPOSED TO (BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIAL)? BE SPECIFIC:

WHAT PARTS OF YOUR BODY BECAME EXPOSED? BE SPECIFIC:

ESTIMATE THE SIZE OF THE AREA OF YOUR BODY THAT WAS EXPOSED.

FOR HOW LONG?

DID A FOREIGN BODY (NEEDLE, NAIL, AUTO PART, DENTAL WIRES, ETC.) PENETRATE YOUR BODY?

YES NO

IF YES, WHAT WAS THE OBJECT?

WHERE DID IT PENETRATE YOUR BODY?

WAS ANY FLUID INJECTED INTO YOUR BODY? YES NO

IF YES, WHAT FLUID? HOW MUCH?

DID YOU RECEIVE MEDICAL ATTENTION? YES NO

IF YES, WHERE?

WHEN?

BY WHOM?

**Section Below, to be Completed By School Nurse**

IDENTIFICATION OF SOURCE INDIVIDUAL(S)

NAME(S)

DID YOU TREAT THE PATIENT DIRECTLY? YES NO

IF YES, WHAT TREATMENT DID YOU PROVIDE? BE SPECIFIC:

OTHER PERTINENT INFORMATION: (Please attach.)

**The Supervisor/School Nurse should provide a copy of the following for the employee to take to the Healthcare Provider:**

1. **This Exposure Incident Report**
2. **The blank Healthcare Professionals Written Opinion** **Form**
3. **A Copy of the *Bloodborne Pathogens Standard* (29 CFR 1910.1030)**