Exposure Incident Documentation Form

Employee Information:

Name:_____ Social Security Number: _____-_____-_____
Position:_____ FTE_____ Shift Hours:_____
HBV Vaccination Series completed? ☐ YES ☐ NO Clinic:_____

Exposure Incident Information:

Description of employee's duties as they relate to the exposure incident:_____
Site where exposure incident occurred:_____
Date of exposure incident:_____ Time of exposure incident:_____
Route(s) of exposure:_____
Description of incident and circumstances under which it occurred:_____
_____
Types of protective equipment in use during the exposure incident:_____
_____
Witnesses to incident (Name / Position):_____
Were any medical sharps such as needles or lancets involved in the exposure? YES / NO

- I understand that all information pertaining to this incident is to remain confidential.
- I have made the decision **TO OBTAIN / NOT TO OBTAIN** (circle one) a medical evaluation regarding this possible exposure.
- I have been advised that it is my responsibility to obtain a medical evaluation **within 24 hours** of this exposure and I may obtain this evaluation from the recommended health care provider or a provider of my choice.
- I have been advised that the findings from the evaluation will be communicated to me directly from the Health Care Provider.
- I have been informed of the applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
- I have received all the documents necessary to continue with the processing of this incident / claim.

_____ _____
Employee Signature Date

_____ _____
Administrator / Supervisor Signature Date

Source Individual Information Form

To be completed by Administrator / Supervisor

Director of Human Resources: This document must be held in a confidential manner until a Health Care Provider determines if an exposure incident has occurred, and if the source individual needs to be evaluated. If source information is not requested by the Health Care Provider within 30 days, this information document must be destroyed.

Source Individual / Student

Source Student: *Name:* _____
Address: _____
_____
Phone: _____

Was the source individual's Parent/Guardian notified of incident? ☐ YES ☐ NO

By Whom: _____ Date and Time of notification: _____

Comments: _____
_____
_____

Source Individual / NON-Student

Source Individual *Name:* _____
Position: _____

Was the source individual notified of incident: ☐ YES ☐ NO

By Whom: _____ Date and Time of notification: _____

Comments: _____
_____
_____

_____ _____
Administrator / Supervisor Signature Date