



# Employee Exposure Incident Report

In case of an actual or a potential exposure to Bloodborne Pathogens or Other Potentially Infectious Materials, as defined in the city's *Exposure Control Plan*, complete this form and return to human resources within 24 hours. If other persons were involved, attach additional copies of this form for each person involved. A *Supervisor's Report of Accident* form must also be completed.

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Department: \_\_\_\_\_ Report Date: \_\_\_\_\_

Division: \_\_\_\_\_ Report Time: \_\_\_\_\_

Job Title: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Place where the exposure incident occurred:

*Include specific work area, address, CAD/ICR number, etc.*

Did the incident arise out of and in the course of City employment? Yes No

Supervisor: \_\_\_\_\_

Witnesses:

Name Address Telephone

Name Address Telephone

### Exposure to

- Blood
- Body fluid with visible blood
- Vaginal secretions
- Seminal fluid
- Other Potentially Infectious Materials: \_\_\_\_\_

### Type of Exposure

- Needle stick/sharps accident
- Contact with skin
- Contact with mucous membranes

# Exposure Incident Report

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## Severity of Exposure

How much fluid? \_\_\_\_\_

How long was exposure? \_\_\_\_\_

Describe the incident and the circumstances of the exposure:

Personal Protective Equipment (PPE) in use at time of exposure:

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## Investigation of Source

*Please describe what information is known about the source of the exposure (the person's name, address, telephone number, or other contact point), the result(s) of the blood testing of the source person (if known), or why blood testing of the source person is not feasible. Also, if the source person is known to have or test positive for hepatitis B or human immunodeficiency virus (HIV), please indicate. The source person should be tested for these agents unless such testing is not legally possible.*

What immediate first aid or other interventions were done after the exposure?

Has the exposed employee been immunized against the Hepatitis B virus?                      Yes                      No

Dates of Immunizations: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_