



HUMBOLDT COUNTY

EXPOSURE INCIDENT REPORT

BLOODBORNE PATHOGEN/AIRBORNE/SHARPS

Medically Sensitive and Confidential

Employee Report

Date of Incident: _____ Time: _____ A.M. _____ P.M.

Employee Name: _____ SS#: _____

Department: _____ Division: _____ Position: _____

Incident Location: _____

Type of Exposure: cut, laceration, puncture splash (eyes, nose, mouth) other

If other, describe: _____

Type of body fluid with visible blood: _____

Part of Body Exposed: Skin Break Mouth Eyes Other

If other, describe: _____

Describe how and why exposure occurred, including the job task being performed at the time of the exposure, and the extent and duration of the exposure.

Measures performed after the incident (check all that apply):

- Washed affected part
- Flushed with water
- Allowed wound to bleed
- Applied antiseptic
- Reported to supervisor
- Evaluated by medical consultant

Personal Protective Equipment Used: gloves mask goggles face shield gown

other If other, describe: _____

Date Exposure Reported: _____ Time Reported: _____ A.M. _____ P.M.

Exposure Reported To: _____ Title: _____

Supervisor Report

Source of Exposure (if known): _____ Phone No: _____

Consent to HIV/HBV Testing: Yes No

Date: _____ Signature: _____

Only two copies are to be prepared. The original is to be provided to the employee for delivery to the medical professional to which he or she has been referred for evaluation and follow-up. The copy is to be sent in a sealed envelope marked "Medically Sensitive and Confidential Information - to be Opened by Addressee only" to the Risk Management Division, 825 5th St., Eureka, CA 95501



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To be completed by Health Care Provider/Designated Person

1. Did the employee see a physician regarding the exposure: Yes No
 If yes, Name of Physician: _____ Phone #: _____
 Date seen: _____ Time: _____ A.M. _____ P.M.
 Physician's Instructions: _____

2. Did the employee request to be monitored for HBV and HIV antibodies following the exposure?: Yes No
 If no, why not: _____

3. Source of exposure (if known): _____ HBV+ HIV+

4. Evaluation/treatment (include condition of skin if applies): _____

5. Follow-up of employee (including referrals): _____

Tests Ordered

Employee:

Results:

- Hepatitis Profile
- HIV Consent Signed
- Hepatitis Post Screen
- None Necessary

Source:

Results:

- Hepatitis Profile
- HIV Consent Signed

Treatment Given Employee

- Seen by Public Health: _____ Date: _____
- Reviewed by Medical Director: _____ Date: _____
- Immune Globulin Tetanus Toxoid AZT
- Hyper Immune Globulin HBV Vaccine Other: _____

Name of Physician Seen: _____ Phone No.: _____
 Address: _____

Describe corrective action taken to prevent recurrence of exposure, if any:

Date: _____ Signature: _____
 Title: _____ Print Name: _____