

Form 9-a7

Blood and Body Fluid Exposure Report

| | | | | | | | | | | | |
|--|--|--|--|--|-----------------------|---------------------------------------|-----------------|----|--|--|--|
| Employee Name: | | | | | Date of Birth: | | | | | | |
| | | Last | | First | | MI | | | | | |
| SSN: | | | | Employee #: | | | Dept. #: | | | | |
| Job Title: | | | | | | | | | | | |
| Hepatitis B Vaccination status: | | <input type="checkbox"/> Series complete | | <input type="checkbox"/> In process | | <input type="checkbox"/> Denied | | | | | |
| Injection Dates: | | #1 | | | #2 | | | #3 | | | |
| Date of Exposure: | | | | | | | | | | | |
| Date Exposure Reported: | | | | | | | | | | | |
| Time of Exposure (Approximate, if unknown): | | | | | | | | | | | |
| Responsible Person: | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| Good Samaritan: | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| Description of the Incident: (Include causes, where and how it occurred, and body parts involved.) | | | | | | | | | | | |
| Body Fluids Involved: | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| Exposure was to: | | | | <input type="checkbox"/> Non-Intact Skin | | <input type="checkbox"/> Intact Skin | | | | | |
| Exposure source known? | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| Consent obtained for HIV/HBV testing? (If yes, attach nameless copy of lab results to this form.) | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| Indicate type of Personal Protective Equipment (PPE) used for this procedure: | | | | <input type="checkbox"/> Glove | | <input type="checkbox"/> Goggles | | | | | |
| | | | | <input type="checkbox"/> Mask | | <input type="checkbox"/> None | | | | | |
| | | | | <input type="checkbox"/> Gown | | <input type="checkbox"/> Other | | | | | |
| Was the PPE available for your use: | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | | | |
| | | | | <input type="checkbox"/> Don't know | | <input type="checkbox"/> N/A | | | | | |
| If NO, indicate why not: | | | | | | | | | | | |
| Referred to: | | | | | | Phone: | | | | | |
| Additional Comments: | | | | | | | | | | | |
| Completed? | | | <input type="checkbox"/> Injury/Illness Report | | | <input type="checkbox"/> OSHA 300 Log | | | | | |
| | | | <input type="checkbox"/> First Report of Injury (Workers' Compensation Claim Form) | | | | | | | | |

Name of Preparer (print)

Title of Preparer

Date Form Completed

SAMPLE