[AGENCY]_____ EXPOSURE/COMTAMINATION FORM

(Completed by emergency worker at the time of the incident)

Phone Number of Agency Contact: _____

Demographics

Name: _____ Date of Incident _____ Time of Incident_____

Run Number: _____ Shift: _____ Unit #: _____ Emp#: _____ SSN: _____

Home address: _____

Street City State Zip

Phone: (Work)_____(Home)_____

Last Tetanus: _____ **HepB/Ab status:** _____

Hazardous Materials:
List material if known

Exposure/Contamination Description:

A. Blood or Body Fluids

____Blood or body fluids into natural body openings (nose, mouth, eye)
____Blood or body fluids into cut or wound less than 24 hrs old
____Needlestick with contaminated needle ___ noncontaminated needle
____Blood or body fluids on intact skin, clothing or turn-out gear, PPE
____Treated or transported known infected/contaminated patient (List known substance _____
____Other (describe)_____
_____
_____

B. Respiratory

____Mouth-to-mouth resuscitation ____Resuscitation using airway
____ Other (describe) _____
_____
_____

Type of substance(s) to which you were exposed to: _____
_____

Type of PPE used at time of exposure/contamination: _____
_____
_____

Describe any action taken in response to the exposure/contamination: _____
_____
_____

Describe the incident in detail: _____
_____
_____
_____

Witness(es) to Incident: _____

Employee's Signature: _____ Supervisor's Signature: _____

Source of Exposure (NOT for Contamination)

Patient's Name: _____ Gender: M F DOB: _____

Hospital Receiving Pt _____ Form Delivered to: _____ Date: _____
(Hospital Representative)

Treatment Adminstered (if any): _____

Return to Work Status: ____ No Restrictions ____ Modified Restrictions _____
____ Unable to return to work for _____ days. Why _____

Referral: _____IDCO ____Primary Care/Agency Physician _____ WorkComp Physician

Please contact _____ for reporting results: _____