

# BLOODBORNE EXPOSURE INCIDENT REPORT FORM

TO BE COMPLETED WITHIN 24 HOURS OF THE INCIDENT AND SENT TO THE EXPOSURE CONTROL OFFICER

PLEASE TYPE OR PRINT

## EMPLOYEE IDENTIFICATION

Name	Home Street Address	
	City, State, Zip	
Home Phone	Work Phone	Dept.
SSN	Birthdate	Job Title

## INCIDENT INFORMATION

Date of Incident	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Location of Incident		
What types of potentially infectious materials were involved in the incident?		
What was the source of the material?		
Describe in detail the circumstances under which the incident occurred.		
How was the incident caused (accident, equipment malfunction, power outage, etc)?		
What personal protective equipment was being used at the time of the incident?		
Describe actions taken as a result of the incident.		
Employee Decontamination <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cleanup <input type="checkbox"/> Yes <input type="checkbox"/> No		
Notifications Made <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date and Time of Notification		

## SIGNATURE

Employee's signature	Date
Print Name	