



Infectious Exposure Form

Exposed Member's Name: _____ Position: _____

Soc. Sec. #: _____ Home Phone: _____

Field Inc. #: _____ Shift: _____ Company: _____

Name of Patient: _____ Sex: _____

Age: _____ Address: _____

Suspected or Confirmed Disease: _____

Transported to: _____

Transported by: _____

Date of Exposure: _____ Time of Exposure: _____

Type of Incident (auto accident, trauma): _____

Type of protective equipment utilized: _____

What where you exposed to:

Blood _____ Tears _____ Feces _____ Urine _____ Saliva _____

Vomit _____ Sputum _____ Sweat _____ Other _____

What part(s) of your body became exposed? Be specific: _____

Did you have any open cuts, sores, or rashes that became exposed? Be specific: _____

How did exposure occur? Be specific: _____

Did you seek medical attention? _____ Yes _____ No

Where? _____ Date: _____

Contact Infection Control Supervisor: Date _____ Time: _____

Supervisor's Signature: _____ Date: _____

Member's Signature: _____ Date: _____

InfectionControlSupervisor'sReport

Medicalfacilitynotified? Yes _____ No _____

IfYes:

NameofFacility: _____ Date: _____

AddressofFacility: _____

NameofFacilityContact: _____

ConfirmedExp osure: _____

Membernotified? Yes _____ No _____

Member'sSignature: _____ Date: _____

MedicalFollow -UpAction:

Remarks:

InfectionControlSupervisor'sSignature: _____ Date: _____