

Oswego County Opportunities, Inc.
Bloodborne Pathogens
Employee Exposure Report Form



Employee Name: _____

SSN: _____ - _____ - _____

Home Address: _____

Program/Division: _____

Position Title: _____

Home Phone: _____

Supervisor: _____

A. Briefly describe the exposure incident: _____

B. Supervisor was notified on: Date: _____ Time: _____ a.m. p.m.

C. Complete the following section(s):

1. Wound

a. Were you wounded during the incident? Yes No

b. Did your wound result in visible bleeding? Yes No

c. Your wound was caused by:

Needle Other sharp instrument (specify): _____

Human bite Other (specify): _____

2. Blood/Body fluid exposure to mucous membranes

a. Did the individual's blood/body fluids come in contact with your body? Yes No

b. What was the substance to which you were exposed?

Blood Saliva Feces Urine Emesis (vomit)

c. If the substance was anything other than blood, was there any blood visible in the fluid?

N/A Yes No Unknown

d. What part(s) of your body was/were exposed to the substance (check all that apply)

None Mouth Eyes Nose Ears Skin (where?) _____ Other: _____

D. How long was/were your body part(s) in contact with the substance?

1. If the exposure was to your skin, did the site of the exposure have a bruise or abrasion?

Yes No

2. What was the nature of the bruise or abrasion?

Acne Dermatitis Cracks due to dry skin Unhealed cuts or scratches

No skin abrasions Other (specify): _____

E. Which of the following procedures were being used at the time of the incident? (check all that apply)

Covered cuts/open wounds with bandages Gloves (vinyl / latex) Mask (paper/cotton) Pocket Mask

Ventilator or Ambu-bag Goggles/Safety Glasses Other (specify): _____

F. First line intervention

1. What did you do after the exposure?

Washed hands/exposed area(s) Changed clothes Showered

Flushed eyes / Rinsed mouth Other (please specify): _____

G. In the event of contact with blood &/or body fluids, seek medical treatment as soon as possible.

H. Return this completed form to your supervisor. (Supervisor please forward the original to HR and a copy to Employee Health)

Employee signature

Date

Time

Supervisor/Division Director signature

Date

Time