

**Southington Public Schools
Southington, Connecticut
BLOOD/BODY FLUID EXPOSURE INCIDENT REPORT**

Employee Name: _____ **Today's Date:** _____
Employee Job Title: _____ **School:** _____
Description of Incident: _____

Date/Time of Exposure: _____ **Duration of Exposure:** _____ **minutes**

Type of Body Fluid Exposed to (check all that apply):

- blood saliva/sputum amniotic fluid urine other: _____
 feces cerebrospinal fluid synovial fluid wound discharge (pus)

Route / Type(s) of Exposure (check all that apply):

Type 1: MUCOUS MEMBRANE: eyes nose mouth other _____

Type 2: SKIN PENETRATION: puncture/incision/laceration/abrasion human bite
 open sore, lesions eczema, skin rash or similar pierced ears other _____

Type 3: CONTACT WITH CLOTHING/SKIN: soaked through clothing drops/spray on clothing
 contact with dried/caked material diluted body fluids other _____

Type 4: NEEDLESTICK: contaminated non-contaminated

IDENTITY OF SOURCE PERSON (if known): _____

SOURCE PERSON CONTACT INFO: _____

FOLLOW-UP ACTIVITIES

- **For Type 1 or 2 Exposure:** Send worker for medical follow-up, fill out both sides of this form, and complete *Employee Work Related Accident Report* form for worker's compensation carrier. Record on OSHA 300 log and sharps injury log (if applicable).
- **For Type 3 Exposure ONLY** (no associated Type 1 or 2 exposure): Review incident and practices to prevent recurrence, if applicable. Complete *Employee Work Related Accident Report*.
- **For Type 4 Exposure (needlestick): If contaminated needle, handle as a Type 1.** If non-contaminated needle, fill out both sides of this form, and complete *Employee Work Related Accident Report* for worker's compensation carrier (No exposure issue). Record on OSHA 300 log and sharps injury log.

POST-INCIDENT INVESTIGATION

Personal Protective Equipment (PPE) used by exposed employee at time of exposure (check all that apply):

- gloves goggles face shield gown jumpsuit
 pocket mask resuscitator other _____

Procedure(s) being performed at time of exposure: _____

Brief Description of the Exposure Circumstances: _____

Employee Name (Print): _____ Title: _____

Employee Signature: _____ Date: _____

Send Completed Report to the Personnel Manager, BOE

THIS SECTION BELOW TO BE FILLED OUT BY PERSONNEL MANAGER ONLY

Employee sent for medical follow-up on _____ (date) to: _____

(medical facility name and address)

Hepatitis B vaccine status:

- 1st dose received _____ declined by employee
 2nd dose received _____ other: _____
 3rd dose received _____

Healthcare professional's written report received on: _____ (date)

Personnel Manager Signature: _____ Date: _____