

### Bloodborne Pathogen Exposure Incident/Accident Report

- Immediate supervisor should complete this form promptly with employee input.
- Please print clearly and forward to the Supervisor

1. \_\_\_\_\_ 2. \_\_\_\_\_  
Employee Supervisor

3. \_\_\_\_\_ 4. \_\_\_\_\_  
Date of Incident/Accident Time

5. \_\_\_\_\_  
Incident/Accident Location and case number (if applicable)

6. Describe the Incident Fully (route of exposure, circumstances; describe type of controls in place at time of incident including engineering controls and personal protective equipment worn; identify unsafe conditions and/or actions; relevant police reports).

7. Describe employee's injury (part of the body/type of injury):

8. Describe first aid/medical treatment (when and by whom):

9. When was the accident reported: \_\_\_\_\_ To whom?: \_\_\_\_\_ If not immediately reported, WHY? \_\_\_\_\_

10. List Names of Witnesses: \_\_\_\_\_

11. Is the source individual known? Yes \_\_\_ No \_\_\_, if so please provide name/address so that consent for blood testing can be obtained.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

12. What corrective action was taken or is planned, to prevent similar accidents from occurring in the future? \_\_\_\_\_

13. Referral to medical evaluator has been done? Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_  
If not explain: \_\_\_\_\_

**NOTE: THE OREGON HEALTH DIVISION "SOURCE CONSENT" FORM WILL BE SENT TO THE SOURCE OR HIS/HER MEDICAL PROVIDER TO ATTEMPT TO OBTAIN PERMISSION FOR SOURCE HIV/HBV BLOOD TESTING. THE MEDICAL EVALUATOR HAS BEEN INFORMED AS TO OUR POLICY AND THE OR-OSHA RULES. ALL MEDICAL DATA IS CONFIDENTIAL.**

NAME OF INVESTIGATOR: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

For additional comments please use additional paper