BLOODBORNE EXPOSURE INCIDENT REPORT

Name: _____

Date of birth: _____ Gender: _____ Marital Status: _____ No. Dependents: ____

Parent/Guardian (if applicable): _____

Location of incident (specific address): _____

Date and time of incident: _____ _____ _____
(Day of week) (Date) (Time, a.m. or p.m.)

Did you return to work during the next scheduled shift? ☐ Yes ☐ No
If "No", will wage loss exceed six work days? ☐ Yes ☐ No ☐ Not sure
Date of return, if returned to work _____

Description of incident: _____
_____
_____

Specify part of body affected and how affected: _____
_____
_____

Name(s) of witness(es) to the incident: _____
_____

Intervention/Attending Physician's name/address/phone number: _____
_____
_____

Outcome: _____
_____

First reported to: _____
Name, Position, Date

List action(s) taken to prevent similar accidents/injuries from occurring: _____

_____

_____

_____

_____

A preventable accident/injury is one in which the employee/client failed to do everything within reason to prevent it from occurring.

In your opinion, was this a ☐ preventable or ☐ non-preventable accident by the employee/client?

Please explain: _____

_____

_____

_____

_____	_____	_____
Signature of Employee	Position	Date
_____	_____	_____
Signature of Supervisor	Position	Date

Check all that apply:

Received Medical Treatment: ☐ Yes ☐ No
Given Work Restrictions: ☐ Yes ☐ No
Absence from work: ☐ Yes ☐ No

HUMAN RESOURCES USE ONLY

Workers' Comp Claim Filed: Yes No N/A Signature: _____ Date: _____