Bloodborne Pathogens
Exposure Incident Reporting Kit

Environmental Health and Safety
Administrative Services Annex North
8600 University Blvd.,
Evansville, IN 47712

Any Questions?
TELEPHONE: (812) 461-5393
FAX NUMBER: (812) 461-5275
EMAIL: Bryan Morrison
The chart below indicates the forms required to report a bloodborne pathogens exposure incident and the responsible party for the completion and disposition of each form. Enclosed is one copy of each of the forms needed to file a workers' compensation claim. If you require additional exposure incident reporting kits, please call Environmental Health and Safety at 461-5393.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Title of Form and Explanation</th>
<th>Responsibility of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHS-1 /BBP</td>
<td>The University of Southern Indiana Environmental Health and Safety Exposure Incident Reporting Form (to be completed by the supervisor and submitted by the end of the work day following the day of injury)</td>
<td>Supervisor</td>
</tr>
<tr>
<td>EHS-2 /BBP</td>
<td>The University of Southern Indiana: Authorization for Medical Treatment (authorizes the injured / ill employee to be treated at the Emergency Room WHEN signed by the supervisor)</td>
<td>Supervisor</td>
</tr>
<tr>
<td>EHS-3/BBP</td>
<td>The University of Southern Indiana Environmental Health and Safety Post-Exposure Evaluation and Follow-Up Form (to be returned to Environmental Health and Safety. EHS will provide employee with a copy of the healthcare professional's written opinion within 15 days of receiving the results of the evaluation.)</td>
<td>Employee and Evaluating Healthcare Professional</td>
</tr>
<tr>
<td>EHS-4/BBP</td>
<td>The University of Southern Indiana Environmental Health and Safety Sharps Injury Log (This form will be completed for all percutaneous injuries resulting from contaminated sharps.)</td>
<td>Environmental Health and Safety</td>
</tr>
</tbody>
</table>

Environmental Health and Safety
8600 University Boulevard
Evansville IN 47712
Telephone: 812 461-5393 / Fax: 812 461-5275
ENVIRONMENTAL HEALTH AND SAFETY
EXPOSURE INCIDENT REPORTING FORM

Section One: Complete For All Bloodborne Pathogens Exposure Incidents

<table>
<thead>
<tr>
<th>Department</th>
<th>Date of Accident</th>
<th>Time Incident Occurred</th>
<th>A.M</th>
<th>P.M.</th>
</tr>
</thead>
</table>

Location (indicate By Building And Room, Or In Relation To Known Fixed Object)

Potentially Infectious Materials Involved:
- **Type:**
- **Source:**

Description of Incident (Be Specific)

Witness Name and Address

Witness Name and Address

Factors in Incident (Be Specific)
- Unsafe Act
- Unsafe Condition

Corrective Action Taken

Supervisor's Comments / Recommendations:

Supervisor Signature

Section Two: Complete For Personal Injuries

<table>
<thead>
<tr>
<th>Name of Injured Person</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Daytime Telephone

Home Telephone

Gender
- Male
- Female

Age

Nature of Injury

Body Part Affected (Indicate Left or Right)

Status of Injured Person
- Faculty
- Staff
- Student
- Other (Specify)

Severity of Injury
- Minor First-Aid
- Severe Non-Disabling
- Disabling
- Fatality

Cause of Injury (be specific)
- Sharps Equipment / Tools
- Needlestick
- Other:

Protective equipment:
- Was Required
- Was Available
- Was Used
- Was Not Sufficient to Prevent Injury

Section Three: Complete for USI Employees

<table>
<thead>
<tr>
<th>Social security number</th>
<th>Average weekly gross $</th>
<th>Employed by USI Yrs. Mos.</th>
<th>Time in present position Yrs. Mos.</th>
</tr>
</thead>
</table>

Job title

Status
- full time
- part time

Injured on the job
- Yes
- No

Job performing when injury occurred

Stopped work immediately
- Yes
- No

Est. time lost from work

Medical treatment provided by

Date supervisor learned of injury (Month) (Day) (Year)

Form EHS-1/BBP
THE UNIVERSITY OF SOUTHERN INDIANA
AUTHORIZATION FOR MEDICAL TREATMENT

Supervisor to complete:
Employee ______________________________________ Date ________________________________
Department _____________________________________ Job Title ________________________________

has suffered a work related injury/illness and is authorized to receive treatment at the local hospital emergency room

____________________________________________
Signature of Supervisor

Attending physician to complete:
Nature of injury or illness:

____________________________________________________________________________________

Treatment: __________________________________________________________________________

Disposition (please indicate below):

Return to work
Temporarily disabled from ________ to ________. Estimated fit for duty on ________.
Return to work, limited duty for ________ days. Estimated fit for duty on ________.
Restrictions on work activity: ________
Prescribed medications.
Referred to private physician
Admitted to the hospital

Date                      ____________________________________________
Signature of Physician

Pharmacy to complete:
Issued the following medications:

____________________________________________________________________________________

____________________________________________________________________________________

Date                      ____________________________________________
Signature of Pharmacist

INSTRUCTIONS:
1 Supervisor completes top portion.
2 Employee gives form to treating physician.
3 Employee returns complete form to supervisor.
4 Supervisor sends copy of completed form to:

Environmental Health and Safety
8600 University Boulevard
Evansville IN 47712
POST-EXPOSURE EVALUATION AND FOLLOW-UP FORM


CONFIDENTIAL: MEDICAL RECORDS

Please provide this form to the evaluating healthcare professional before the evaluation. Upon completion of the evaluation, this form should be sent by the healthcare professional to Environmental Health and Safety.

INJURED EMPLOYEE’S NAME: ________________________________ DEPARTMENT: ________________________________

As part of my employment with the University of Southern Indiana, I may have been exposed to blood or other potentially infectious materials on the following date: ________________________________

(INSERT DATE)

A description of job duties as they relate to the exposure incident:

The route of exposure was:

The name and address of the source individual is: UNKNOWN

OR

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(SOURCE INDIVIDUAL’S NAME)</td>
<td>(ADDRESS)</td>
<td>(CITY)</td>
</tr>
</tbody>
</table>

Check the following items that apply:

- Exposure Incident Report Form (Form EHS-1/BBP) has been completed (copies forwarded to Environmental Health and Safety)
- Source individual’s blood has been tested (provided consent obtained)
- Exposed employee has been notified and / or Hepatitis B Immune Globulin at no charge to myself.

Initial

Please check the following that apply:

- I accept the Hepatitis B vaccination series.
- I accept the Hepatitis B Immune Globulin.
- I decline the Hepatitis B vaccination series.
- I decline the Hepatitis B Immune Globulin.
- I consent to baseline blood collection and HBV serological testing.
- I do not consent to baseline blood collection.
- I consent to baseline blood collection but do not consent to any testing at this time. I understand that the blood sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, I elect to have baseline samples tested for either HBV or HIV, such testing shall be done as soon as feasible.

To the evaluating healthcare professional:

After your evaluation of this University of Southern Indiana employee, please assure that the following information has been furnished to the employee and provide your initials beside the following statements:

- The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.
- The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.
- Hepatitis B vaccination is ___________ is not ___________ indicated.

All other findings or diagnoses shall remain confidential and shall not be included in the written report. The employer is afforded access to the limited information stated above. Any information regarding the results of the employee’s evaluation or medical conditions must be conveyed by the health care professional to the employee alone and not as part of the written opinion that goes to the employer.

Healthcare Professional’s Name ________________________________

Healthcare Professional’s Signature ________________________________ Date ________________________________

Form EHS-3/BBP
EVALUATION OF CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

Evaluation of circumstances surrounding an exposure incident is to be done by Environmental Health and Safety or designee. The evaluation will consist of at least:

- A review of the Exposure Incident Investigation Form completed by the supervisor;
- Documentation regarding a plan to reduce the likelihood of a future similar exposure incident;
- Notification to the exposed employee’s department and discussion of any similar incidents and planned precautions; and;
- Completion of the “Sharps Injury Log” (Form EHS-4/BBP).

Such reports will be maintained in Environmental Health and Safety, and a copy is to be sent to the department where the employee is assigned. Environmental Health and Safety will review these reports on a periodic basis so that reported information can be considered in the review and update of the Exposure Control Plan.
**SHARPS INJURY LOG**

In accordance with 29 CFR 1910.1030 (h)(5), Bloodborne Pathogens Standard.

Environmental Health and Safety will complete a log for each employee exposure incident involving a sharp.

### PERSONAL INFORMATION:

<table>
<thead>
<tr>
<th>PRINT: First Name, Middle Initial, Last Name</th>
<th>Daytime Phone</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>SUPERVISOR</th>
<th>A.M. /</th>
<th>P.M.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION WHERE INJURY OCCURRED (BUILDING NAME AND ROOM NUMBER)</th>
<th>DATE &amp; TIME OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brief explanation of how incident occurred:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

### FILL IN THE ONE CIRCLE CORRESPONDING TO THE MOST APPROPRIATE ANSWER.

**Procedure:**

- ○ Draw venous blood
- ○ Draw arterial blood
- ○ Injection, through skin
- ○ Start IV/set up heparin lock
- ○ Unknown / Not Applicable
- ○ Other

**Identify sharp involved:**

- (if known)

**Body Part:**

- ○ Finger
- ○ Face/Head
- ○ Hand
- ○ Torso
- ○ Arm
- ○ Leg
- ○ Other

**Exposure employee:** If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury?

- ○ YES
- ○ NO

**Exposed employee:** Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury?

- ○ YES
- ○ NO

**Did the device being used have engineered sharps injury protection?**

- ○ Yes
- ○ No
- ○ Don't Know

**Was the protective mechanism activated?**

- ○ Yes-fully
- ○ Yes-partially
- ○ No

**Did the exposure incident occur:**

- ○ Before
- ○ During
- ○ After activation

**Exposure employee:** If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury?

- ○ YES
- ○ NO

**Exposed employee:** Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury?

- ○ YES
- ○ NO

<table>
<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EHS SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form will be completed by and maintained in Environmental Health and Safety through interviews.

This sharps injury log will be maintained for five years following the end of the year in which the incident occurred.