Appendix E
Occupation Exposure Incident Report

OCCUPATIONAL EXPOSURE INCIDENT REPORT

Name_____**Date**_____
Date Reported_____**Reported to**_____
Type of Exposure Incident:_____
_____
_____
_____
_____
How did exposure incident occur:_____
_____
_____
_____
List protective devices used at the time of exposure: _____
_____
_____
_____

Description of Employee's duties as related to occupational exposure: _____
_____
_____
_____
_____
Date of Hepatitis B Vaccination: _____
_____ _____
Signature of Person Preparing Report **Date** **Employee Signature** **Date**

Source Individual's Blood Drawn: **Yes**_____ **No**_____ **Date**_____
If NO state reason: _____
_____
_____
Signature
Employee's Blood Drawn: **Yes** _____ **No**_____**Date**_____
In NO state reason: _____
_____
_____
Signature
Results of Employee's laboratory results and results of source individual laboratory results discussed with employee: **Yes**_____ **No**_____
If NO state reason: _____
_____
_____
_____ _____
Employee Signature **Date**

Copy of Regulation to M.D.: Yes_____ **No**_____ **Employee: Yes**_____ **No**_____

Physician's Opinion:

_____
_____
_____
_____
_____
_____
_____

_____ _____
Date M.D. Signature

Counseling on illness reporting and safe effective post prophylaxis: Yes _____No _____
Employee agreeable to further testing: Yes_____ No _____
Employee Agreeable to further testing: Yes_____ No_____

_____ _____ _____ _____
Signature of Counselor Date Employee Signature Date

Follow-Up 6 weeks_____
_____
_____ _____
Signature Date

Follow-Up 12 weeks_____
_____
_____ _____
Signature Date

Follow-Up 6 Months_____
_____
_____ _____
Signature Date

Follow-Up 1 Year (optional)_____
_____
_____ _____
Signature Date

Follow-Up 2 Year (optional)_____
_____
_____ _____
Signature Date