Department of Education

Joel Klein
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Bloodborne Pathogens Standard

29 CFR 1910.1030

Exposure Incident Package

INSTRUCTIONS: Use the forms in this package to report occupational exposure incidents.

Exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Employee Exposure Incident Report		
NAME OF FORM	PAGE	ACTION
Part 1 – Employee Exposure Incident Report	1 – 2	1. Completed by employee 2. Employee receives a copy
Part 2 – Employee Exposure Incident Report	3	1. Completed by Administrator 2. Employee receives a copy
Part 3 – Health Care Professional Designated to Counsel Exposed Employee	4	1. Completed by Health Care Professional Designated to Counsel Exposed Employee
Part 4 – Employee Exposure Incident Report	5	1. Employee gives blank copy of this form to the employee's medical provider 2. Completed by employee's medical provider and returned within 10 days unless employee completes the Declination Form
Employee Declination of Post-Exposure Evaluation		
NAME	PAGE	ACTION
Exposed Employee Declination to receive Medical Evaluation and Follow-up After an Exposure Incident	6	1. Completed by employee if refusing medical attention
Identification and Evaluation of Source Individual (if known)		
NAME	PAGE	ACTION
Part A – Identification and Evaluation of Source Individual	7	1. Completed by Site Administrator
Part B – Identification and Evaluation of Source Individual	8	1. Part A completed by Site Administrator 2. Part B completed by Medical Provider
Employee's Exposure follow-up Record		
NAME	PAGE	ACTION
Part A – Exposed Employee Follow-up Record	9	1. Completed by Employee
Part B – Employee's Exposure follow-up Record	10	1. Provide Employee with blank form to give to Medical Provider 2. Completed by Employee's Medical Provider
Exposure Incident Report Log	11	1. Completed and maintained by Site Administrator 2. Copy sent to OOSH

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Completed by Exposed Employee

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Employee Exposure Incident Report – Part 1

Please print all information

DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #"	Home Telephone #:

EMPLOYEE HEPATITIS B VACCINATION STATUS	
Have you received the HBV vaccine? ☐YES ☐ NO	Date Dose #1 Received:
If NO, did you complete an Employee Vaccination Declination form? ☐YES ☐ NO	Date Dose #2 Received:
	Date Dose #3 Received:

EXPOSURE INCIDENT	
Date of Exposure:	Time of Exposure: ☐ AM ☐ PM
Where Did The Incident Take Place?	
Nature Of The Incident:	
What Tasks Were You Performing When The Exposure Took Place?	

PERSONAL PROTECTIVE EQUIPMENT - PPE	
Were you wearing Personal Protective Equipment? ☐YES ☐ NO	If YES, Describe what type:
Did the PPE Fail? ☐YES ☐ NO	If YES, Describe how:

INCIDENT EXPOSURE		
Were You Exposed To Blood, Body Fluids Or Other Potentially Infectious Materials? ☐YES ☐ NO	What Body Fluids Were You Exposed To?	
What Part(s) of your Body was Exposed?	Estimate the Size or Area of your Body that was Exposed	
How Long Did The Exposure Last?		
Did A Foreign Body (Needle, Nail, Auto Part, Dental Wires, Etc.) Penetrate your Body? ☐YES ☐ NO	If YES, Identify the Object:	
Was Fluid Infected Into Your Body? ☐YES ☐ NO	If YES, Identify the Fluid	How Much Fluid?

IDENTIFICATION OF SOURCE INDIVIDUAL(S)	
Name/ Affiliation # 1:	
Name/ Affiliation # 2:	

_____
Employee Signature

_____
Principal's Signature

_____
Date

_____
Date

This form and related documentation will be kept on file by the New York City Department of Education for the length of employment and 30 years. This form and related documentation will remain confidential. Personal identifying information will be released with the employee's consent only.

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Completed by Site Administrator

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Employee Exposure Incident Report – Part 2

Please Print All Information

DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #"	Home Telephone #:

REPORTING
Is A Comprehensive Accident Report Detailing This Incident On file? ☐YES ☐ NO
Is An SH 900 and Related Documents Detailing this Incident On File? ☐YES ☐ NO ☐ NOT APPLICABLE

SUBMIT COMPLETED COPY TO:	
RISC Safety and Health Liaison (enter name and address)	New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

_____
Employee Signature

_____
Principal's Signature

_____
Date

_____
Date

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Completed by Health Care Professional
Designated to Counsel Exposed Employee

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Employee Exposure Incident Report – Part 3

NOTE - OSHA's Bloodborne Pathogens Standard cited as 29 CFR 1910.1030 requires that post-exposure counseling be given to employees following an exposure incident. Counseling should include USPHS recommendations for transmission and prevention of HIV. These recommendations include refraining from blood, semen, or organ donation; abstaining from sexual intercourse or using measures to prevent HIV transmission during sexual intercourse; and refraining from breast feeding infants during the follow-up period. In addition, counseling must be made available regardless of the employee's decision to accept serological testing.

HEALTH CARE PROFESSIONAL	
Health Care Professional Name:	Title:
Office Location:	
Telephone:	Fax Number:
EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Home Address:	
Home Telephone:	Social Security #:
EXPOSURE INCIDENT	
Employee Job Description:	
Date of Exposure:	Date Exposure Reported:
Exact Location of Exposure:	
Type of Exposure:	
Source of Individual:	
Immediate Action Taken:	
Treatment Provided:	
Recommendation:	
Referral:	
Comments:	

_____ _____

Health Care Professional/Counselor Signature Date

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Completed by Exposed Employee's Medical Care Provider

Bloodborne Pathogens Standard

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Employee Exposure Incident Report – Part 4

EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Date of Birth:	Social Security #:
Work Site Name:	Work Telephone:
MEDICAL CARE PROVIDER	
Health Care Professional Name:	Title:
Office Location:	
Telephone:	Fax Number:
MEDICAL CARE PROVIDER'S REPORT	
Did You Treat The Patient/Employee Directly? ☐YES ☐ NO	
If YES, Specify Treatment Regimen:	
Other Pertinent Information:	

_____ _____

Medical Care Provider's Signature Date

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Completed by Exposed Employee
Declining Medical Evaluation and Follow-up

Bloodborne Pathogens Standard

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Employee Declination of Post-Exposure Evaluation Form

I was exposed to blood and other potentially infectious body fluids at my worksite on _____. As a result of this incident, I have completed the required incident report and was advised by Administration to seek medical evaluation and follow up by a Physician or Health Care Provider immediately. I decline medical evaluation.

Employee's Last Name:	Employee's First Name:	
Job Title:	Social Security #:	
Work Site Name:		
Work Site Address:		
Region#:	District:	Work Telephone:

_____ _____
Exposed Employee Signature Date

_____ _____ _____
Site Administrator's Name Site Administrator's Signature Date

_____ _____ _____
Principal's Name Principal's Signature Date

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Completed by Site Administrator

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Identification and Evaluation of Source Individual - Part A

EXPOSED EMPLOYEE		
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #:	Job Title:
Work Site Name:	Work Telephone:	Home Telephone:
MEDICAL CARE PROVIDER		
Health Care Professional Name:	Affiliation:	
Address:		
Telephone:	Fax Number:	
INCIDENT INFORMATION		
Date of Incident:	Name or Record Number or Source Individual	
Check ☑ the most appropriate:		
☐	Blood or Body Fluid Splashed into Mucus Membrane or non-Intact skin	
☐	Contaminated Needle Stick Injury	
☐	Other:	
Signature	Date	

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

DO NOT RETURN THESE FORMS TO THE SCHOOL. FORMS MUST REMAIN IN EXPOSED EMPLOYEE MEDICAL FILE

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Part 1 - Completed by Site Administrator
Part 2 – Completed by Source Individual's Medical Provider

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Identification and Evaluation of Source Individual - Part B

Part 1

MEDICAL CARE PROVIDER	
Medical Care Provider's Name:	Affiliation:
Address of Medical Care Provider:	
Telephone:	Fax Number:

Part 2

REPORT OF SOURCE INDIVIDUAL EVALUATION Return this report to the above named Exposed Employee's medical provider	
Testing of source Individual's Blood: ☐ Consent Obtained ☐ Consent Refused	
TEST RESULTS	
Check ☑ One	
☐	Evaluation of source individual evidenced to known exposure to bloodborne pathogens
☐	Evaluation of source individual evidenced possible exposure to bloodborne pathogens. Medical follow-up recommended
☐	Identification of source individual infeasible or prohibited by State or Local Law. State why:
Name/Affiliation of Person Completing This Report:	
Signature	Date

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

DO NOT RETURN THESE FORMS TO THE SCHOOL. FORMS MUST REMAIN IN EXPOSED EMPLOYEE MEDICAL FILE

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Part 1 - Completed by Exposed Employee

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Employee's Exposure Follow-Up Record - Part 1

Part 1

EXPOSED EMPLOYEE INFORMATION	
Exposed Employee Name:	Date Completed:
Work Site Name:	Work Site Address:
Job Title At Time of Exposure:	
Date of Exposure:	Time of Exposure:
SOURCE INDIVIDUAL FOLLOW-UP	
Name of Source Individual:	
Request Made To:	Date:
SUBMIT COMPLETED FORMS	
☐ Completed copy forwarded to ISC Safety and Health Liaison	☐ Completed copy forwarded to: Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel. 718-935-2319 Fax. 718-935-4682

_____
Employee's Signature

_____
Principal's Signature

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Part 2 - Completed by Exposed Employee's Medical Care Provider

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Employee's Exposure Follow-Up Record - Part 2

EXPOSED EMPLOYEE	
Name/Affiliation:	
Employee's Health File Reviewed ☐YES ☐ NO	Date:
Blood Sampling/Testing Offered/Completed ☐YES ☐ NO	Date:
Vaccination Offered/Issued: ☐YES ☐ NO	Date:
Counseling Offered: ☐YES ☐ NO	

SOURCE INDIVIDUAL BLOOD TESTING
☐ Results made available to employee. Employee has been informed of medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation and treatment. ☐ Consent not obtained

SUBMIT COMPLETED FORMS	
☐ Completed copy forwarded to ISC Safety and Health Liaison	☐ Completed copy forwarded to: Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel. 718-935-2319 Fax. 718-935-4682

Medical Care Provider's Signature

Employee's Signature

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Completed and Maintained by Site Administrator

Calendar Year:

Bloodborne Pathogens Standard - Exposure Incident Report Log

This form logs Exposure Incident Reports for your facility. Information provided on this form must be recorded and maintained in such a manner as to protect the confidentiality of the injured employee. Forward completed form at the end of each calendar year to: The Office of Occupational Safety and Health, 65 Court Street, Room 706, Brooklyn, NY 11201.

Facility Name:	Principal's Name:
Facility Address:	Facility Phone:

#	DATE OF EXPOSURE	LOCATION OF INCIDENT	ROUTE(S) OF EXPOSURE	NATURE OF INCIDENT	ID AND DOCUMENT SOURCE INDIVIDUAL	PROVIDE MEDICAL EVALUATION & FOLLOW-UP Medical Care Provider Name & Title	DESCRIPTION OF EXPSOURE
1.					YES NO		
2.					YES NO		
3.					YES NO		
4.					YES NO		
5.					YES NO		