BBP INCIDENT REPORT

DATE: ________________  SEND TO: Terri Steih, Human Resource Department

FROM: ________________________  SUBJECT: Possible BBP Exposure Incident

Victim Name: ________________________________________________________________

Date of Incident: ________________  Time: __________________________

Member or Members of Team Involved: __________________________________________

Location of Incident: _________________________________________________________

Description of Incident: ______________________________________________________

____________________________________________________________________________

Was first aid given?  YES ________ NO ________  If yes, what type of aid was provided?

____________________________________________________________________________

Was outside medical assistance required?  YES ________ NO ________  If yes, did you have any problems notifying medical assistance or have any other problems?  Please explain.

____________________________________________________________________________

Please indicate any additional training or changes in our procedures that will help in any future incidents. __________________________________________________________

____________________________________________________________________________

Signature of Person Reporting: ________________________________________________
NOTE: If Team member or members were exposed to Blood or OPIM in an incident, complete evaluation of exposure report. Exposure is defined as contact to eyes, mouth, nose, non-intact skin, or a puncture through the skin, to blood.

EVALUATION OF EXPOSURE INCIDENTS

1. Brief description/circumstances of exposure incident and date:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. Type and brand of device involved in incident exposure: __________________________

3. Source individual information, if available: ________________________________

4. Could the exposure incident have been prevented with proper use of work practice controls?
   Yes_________________     No _______________

5. Is the work practice control in question addresses in the employer’s exposure control plan?
   Yes_________________     No _______________

6. If yes, what is the rationale for non-compliance with the work practice control in question?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

7. Would the utilization of work practice controls have:
   _____ Prevented the delivery of health care or public safety services?
   _____ Posed an increased hazard to the safety of the worker or co-worker?
   _____ Prevented or decreased the risk for occupational exposure?

8. What changes can be instituted to prevent such occurrences in the future?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
9. Was the team member or members sent to a physician because of exposure? If yes, attach a physician’s report.

Date: ______________  Physician Name: ________________________________

10. If the EVALUATION concludes the team member or members was/were exposed to possible Blood or OPIM, did the employer or physician offer the Hepatitis B Vaccine?
    Yes ______________  No ______________

If the Employer or physician offer the Hepatitis B Vaccine, did the team member or members accept or decline the Vaccine program?

    Declined ___________  Accepted ____________

Employee Signature: ___________________________ Date: ______________

    Declined ___________  Accepted ____________

Employee Signature: ___________________________ Date: ______________

    Declined ___________  Accepted ____________

Employee Signature: ___________________________ Date: ______________

    Declined ___________  Accepted ____________

Employee Signature: ___________________________ Date: ______________