MEDIC
Medical Excellence. Compassionate Care.

Exposure Incident Report

Employee Information

Name of Exposed Employee: _____

Employee ID: _____ Phone: _____

Date of Exposure: _____ Time of Exposure: _____

Job Title: _____ Supervisor: _____

Body Part Exposed (mouth, eyes, elbow):_____

Physical Location of Exposure (truck, ER, patient home):_____

Employee wants Safety to follow up with them on the source results if applicable. Yes ☐ No ☐

Section I – Type of Exposure

☐**Percutaneous** – A needle or other sharp object has penetrated the skin.
Complete Sections II, III, and IV *If this is checked then Section II is Required.*

☐**Mucocutaneous** – *(Check Type)*

_____Mucous membrane - Contact of employee's mucous membrane (e.g., eyes, nose, or mouth) with a patient's fluids, such as blood, visibly bloody fluids, and other body fluids (i.e., semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid, or tissues.

____Non-intact skin - Contact of employee's skin with patient fluids, such as; blood, visibly bloody fluids, and other body fluids (i.e., semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid, or tissues. Non-intact skin (broken skin) is any area of the skin that is open by cuts, abrasions, dermatitis, chapped skin, etc.
Complete Sections III, and IV

☐**Human Bite** - A human bite sustained by employee that resulted in non-intact skin.
Complete Sections III and IV

Section II – Needle/Sharp Device Information

A sharp can be any object that penetrates the skin including, but not limited to, needles or broken glass.

Type of Sharp: _____

Name of Device: _____

Brand/Manufacturer: _____

Section III – Employee Narrative

Please describe how the exposure occurred and how it might have been prevented:

_____

_____

Section IV – Exposure and Source Information

A. Hospital account number:_____ _____
B. Exposure Details
   a. Type of fluid or material: _____
C. Source Information
   a. Source individual name: _____
   b. Source transported to: _____
   c. Source date of birth (if known): _____
   d. Source address (if known):_____
   e. Was source testing requested? ____Yes ____No
   f. Who requested the source testing:_____

D. Source Testing Results
   (To be completed by Safety)
   a. Date Results Requested _____
   b. Date Results Received _____
   c. Date Employee Notified _____

Immediate Actions Taken/Needed:

_____

_____

_____ _____
Employee Signature Date

_____ _____
Supervisor or Designee Signature Date