**Bloodborne Pathogen Exposure Checklist**

Employee Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure Incident Date & Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exposure Incident Occurred**

An exposure incident is "unprotected exposure to blood or other body fluids including a skin exposure involving contact with blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis, or a needle/sharp exposure to blood or body fluids." (Small splashes of blood on intact skin is NOT usually classed as an exposure incident.)

**Washing**

Any employee who has an exposure incident should wash the affected area with soap and water or flush eyes or mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or OPIM.

**Notification**

Any employee who has an exposure incident shall **immediately notify a Supervisor.** Employee and*/or* Supervisor will complete the BBP Exposure Incident/Accident Report form. (Appendix 8).

**Medical Treatment**

Medical treatment will be sought as soon as practical. Supervisor will refer the employee to his/her private physician or to a local health care facility for a complete, confidential medical evaluation and follow up. *Prophylaxis treatment is available and most effective when administered as early as possible, ideally within 4 hours of the exposure. Follow-up testing is recommended at 6 weeks, 3 months, and 6 months from the exposure incident.* Employee to complete 801 (Report of Job Injury or Illness).

**Testing**

The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained. The sample shall be analyzed as soon as possible unless the employee does not give consent at that time for HIV serologic testing.

**HBV Series**

If the exposed employee has not previously taken the HBV series, he/she will be urged to be vaccinated immediately. If the employee declines to be vaccinated after an exposure incident, a signed form indicating the employee's choice will be required. (Appendix 7).

**Health Care Provider**

The City will provide the treating physician or healthcare provider with:

a. A copy of the Bloodborne Pathogen rule, 1910.1030.

b. A copy of the BBP Exposure Incident/Accident report. (Appendix 8)

c. Healthcare Professional’s Written Opinion for Post-Exposure Evaluation and Follow-Up form (Appendix 9) which includes requesting the Source Individual’s consent for testing.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medical Treatment:** | Accepted | Declined |  | **Blood**  **Testing:** | Accepted | Declined |
| **Hepatitis**  **Vaccine:** | Accepted | Declined |  | **Follow-up Testing:** | Accepted | Declined |

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bloodborne Pathogen Exposure Incident/Accident Report Appendix 8**

• Immediate supervisor should complete this form promptly with employee input.

• Please print clearly and forward to the Administrative Services Officer/Recorder.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Supervisor

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Incident/Accident Time

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incident/Accident Location and case number (if applicable)

6. Describe the Incident Fully (route of exposure, circumstances; describe type of controls in place at time of incident including engineering controls and personal protective equipment worn; identify unsafe conditions and/or actions; relevant police reports). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Describe employee's injury (part of the body/type of injury) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe first aid/medical treatment (when and by whom) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. When was the accident reported \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not immediately reported, WHY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. List Names of Witnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Is the source individual known? Yes\_\_\_\_No\_\_\_\_, if so please provide name/address so that a consent for blood testing can be obtained.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. What corrective action was taken or is planned, to prevent similar accidents from occurring in the future? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Referral to medical evaluator has been done? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_, Date: \_\_\_\_\_\_\_\_\_\_\_

If not explain:

NOTE: THE OREGON HEALTH DIVISION “SOURCE CONSENT” FORM WILL BE SENT TO THE SOURCE OR HIS/HER MEDICAL PROVIDER TO ATTEMPT TO OBTAIN PERMISSION FOR SOURCE HIV/HBV BLOOD TESTING. THE MEDICAL EVALUATOR HAS BEEN INFORMED AS TO OUR POLICY AND THE OSHA RULES. ALL MEDICAL DATA IS CONFIDENTIAL.

NAME OF INVESTIGATOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_

For additional comments please use additional paper.

**Hepatitis B Vaccination Appendix 7**

**For those WANTING the Hepatitis B Vaccination** (following wording is OSHA required):

I understand that the vaccine should not be given to anyone that is immuno-compromised, allergic to yeast or any other component of the vaccine, or to pregnant women or nursing mothers unless clearly necessary. Relative contraindications include any serious active infection, severely compromised cardiopulmonary function, or any person to whom a febrile or systemic reaction could cause a serious health risk. I certify that, to the best of my knowledge, I do not have any of the above listed conditions, have been informed of the potential risks and benefits of the hepatitis B vaccination, and request to receive the vaccination series by signing and dating this form:

Employee Signature Date

The Hepatitis B vaccination is administered in three applications:

1. Initial application;
2. Second application—occurs 30 days after the initial application;
3. Third application—occurs within 6 months after the initial application.

**For those NOT WANTING the Hepatitis B vaccination** (following wording is OSHA required):

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I hereby acknowledge my refusal to receive the vaccination at this time by signing and dating this form.

Employee Signature Date

**OR**

I DECLINE the Hepatitis B vaccination at this time because I have previously received the completed Hepatitis B vaccination series, or antibody testing has revealed that I am immune, or the vaccine is contraindicated for medical reasons.

Employee Signature Date

**All Affected Employees, whether wanting the Hepatitis B vaccine or not, must sign this**

**form.**

**HEALTHCARE PROFESSIONAL'S WRITTEN OPINION FOR Appendix 9**

**POST-EXPOSURE EVALUATION AND FOLLOW-UP**

DIRECTIONS: This form is to be completed by the healthcare professional following an exposure incident and returned to the employer. The employer will maintain a copy of this form and provide a copy to the exposed employee within 15 days.

**The employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.**  Yes  No

Pursuant to OSHA Standard 1910.1030(f)(3)(ii), the source individual shall be asked to consent to having his/her blood collected and tested for HBV, HCV and HIV. (For source individuals that are minors, their legal guardian will be asked to give consent for testing.) The following information must be recorded:

SOURCE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD TAKEN:  Yes  No DATE TAKEN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WRITTEN/ORAL CONSENT GIVEN FOR: HBV TESTING  Yes  No

WRITTEN/ORAL CONSENT GIVEN FOR: HCV TESTING  Yes  No

WRITTEN/ORAL CONSENT GIVEN FOR: HIV TESTING  Yes  No

RESULTS WILL BE MADE AVAILABLE TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Employee’s Health Care Provider)

NAME OF MEDICAL CENTER AND TREATING PHYSICIAN

HEALTHCARE PROVIDER'S SIGNATURE DATE

**All other findings or diagnoses shall remain confidential and shall not be included in this written report.**

Employer:

City of Pendleton

Attention Human Resources (Confidential)

500 SW Dorion Ave.

Pendleton OR 97801