CONFIDENTIAL
EXPOSURE REPORT

Name of Exposed Individual:_________________________________________________

Agency/Division/Unit:_______________________________   Position:____________

Date Incident Occurred:_____________________________   Time:________________

Name of Source Individual:__________________________________________________

What type of exposure occurred? (i.e., needle stick, cut, spill, etc.)________

Body part exposed? (i.e., mouth, eyes, skin break on hand, etc.)______________

Description of First Aid provided:____________________________________________

Description of task being performed and conditions associated/contributing to the exposure:

In your option has an exposure as defined by WAC 296-62-08001(2) occurred?
Yes ____   No ____

NOTE:  This assessment is to only be made by a qualified health care professional. If there is no qualified person to make this assessment, the employee shall be directed to the health care professional of their choice.

Was the exposed individual instructed/advised to report to a physician    Yes__ No__

Date:___________________   Time:___________________

Has the exposed individual completed an HBV vaccination series?   Yes__   No__

Date of series completion:________________________________________

STATEMENT OF EMPLOYEE CONSENT:  I have provided the above information and agreed to its use pursuant to WAC 296-62-08001(6) which pertains to the provision of a post-exposure evaluation and follow-up when an exposure incident has occurred.

Employee Signature:___________________________   Date:_____________

Report compiled by:___________________________   Date:_____________