

RUSSELLVILLE FIRE DEPARTMENT



"Exceptional Service"

**EXPOSURE REPORT FORM**

**Exposed Employee Information:**

Name: \_\_\_\_\_ Rank: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Incident Information:**

Incident #: \_\_\_\_\_ Shift: \_\_\_\_\_ Company: \_\_\_\_\_ District: \_\_\_\_\_

Incident Location: \_\_\_\_\_

Type of Incident (e.g., auto accident, trauma, etc.): \_\_\_\_\_

**Exposure Description:**

Date of Exposure: \_\_\_\_\_ Time of Exposure \_\_\_\_\_

1. What type of body fluid(s) were you in contact with?

Blood: \_\_\_\_\_ Feces: \_\_\_\_\_ Saliva: \_\_\_\_\_ Sputum: \_\_\_\_\_

Sweat: \_\_\_\_\_ Tears: \_\_\_\_\_ Urine: \_\_\_\_\_ Vomitus: \_\_\_\_\_

Other (describe): \_\_\_\_\_

2. What was the method of contact?

\_\_\_\_\_ Needlestick with contaminated needle

\_\_\_\_\_ Blood or body fluids into natural body openings (e.g., nose, mouth, eye)

\_\_\_\_\_ Blood or body fluids into cut, wound, sores, or rashes less than 24 hours old

Please specify: \_\_\_\_\_

\_\_\_\_\_ Blood or body fluids on intact skin

\_\_\_\_\_ Other (describe specifically) \_\_\_\_\_

3. How did the exposure occur? Be specific; \_\_\_\_\_

4. What action was taken in response to the exposure to remove the contamination (e.g., handwashing):

5. What person protective equipment (PPE) was being used at the time of exposure?

**Exposure Description - (continued):**

6. Please describe any other information related to the incident (use a separate piece of paper if needed):

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**Source of Exposure:**

Name of Patient: (source of exposure: \_\_\_\_\_ Sex: \_\_\_\_\_

Receiving Health Care Facility: \_\_\_\_\_

Transported by: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_

**Medical Information:**

1. Did you seek medical attention? \_\_\_\_\_ Date: \_\_\_\_\_

If yes, where? \_\_\_\_\_

2. Did you contact Infection Control Officer? \_\_\_\_\_

If yes, give date and time: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Infection Control Officer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by Infection Control Officer:**

Communicable disease follow-up needed? Yes\* \_\_\_\_\_ No \_\_\_\_\_

\*If yes, Infection Control Officer must complete the "Communicable Disease Exposure Follow-up Form." This procedure applies either if this is a known disease exposure or if such information is determined at a future date.