

Emergency Medical Service Provider**Exposure Report Form**

PLEASE PRINT OR TYPE

Complete this form to document exposure to blood and/or other body fluids. Most unprotected exposures do not result in an infection, however, some people can be exposed to a disease and not have any symptoms of illness. It is important that you document any significant exposure incident.

Significant Exposure – EMS Provider Information

Exposed Provider, use your last initial, first initial, last 4 digits of Social Security number for ID # ex. (ab1234) ID # _____

Employee Name _____ (Last) (First) (M) DOB ____/____/____ Sex _____ M or F

Home Phone _____ Work Phone _____ Employer/Agency _____

Contact Person at Employment / Agency _____ Contact Phone _____

Date _____ Incident # _____

Mechanism of Exposure (check all that apply)

Body Fluid Exposure	Other Body Fluid w/Blood	How Were You Exposed?
Blood	Saliva	Splash in Eye
Birth Fluids	Urine	Splash in Mouth or Nose
Pericardial Fluids	Feces	Bite
Pleural Fluid	Pus	Puncture w/Hollow-bore Needle
Synovial Fluid	Sputum	Puncture Cut w/Other Sharp Implement
Cerebrospinal Fluid	Other	Open Wound
Semen		Rash / Dermatitis
Vaginal Secretions		Abrasion

What protective equipment were you using at the time of exposure? (check all that apply)

Bag-Valve-Mask	One Way Resuscitation Mouthpiece	Paper Gown
Gloves	N-95 Mask	Other
Eye Protection	Surgical Mask (Less than N-95 rating)	

Source of Significant Exposure – Source Patient Information

Source Patient Name _____ Phone Number _____

Source Patient Address _____ (Street Address) DOB ____/____/____
 _____ (City, State, Zip) Sex: M _____ F _____

I hereby give my permission to the facility named below to draw and test my blood for any or all of the following: HIV Antibody, HBV/Surface Antigen and, HCV Antibody. I understand that the results of this testing are private information and will be confidential.

I refuse to have my blood drawn and tested. I understand that a court order may be pursued to require me to have blood testing done.

Source Patient (or responsible) Signature _____ Date ____/____/____

Receiving Facility/Testing Laboratory

Receiving Facility _____ Date Specimen(s) were obtained ____/____/____

Testing Laboratory _____ Date Specimen(s) were submitted ____/____/____

Did patient expire? Yes No Was the patient under the jurisdiction of the State Department of Corrections (Prisoner or Parolee)? Yes No

Name of Person submitting report _____

Title _____ Phone Number _____ Date Report was submitted ____/____/____

If onsite post exposure counseling is not available contact any of the following. <http://www.ucsf.edu/hivcntr/Hotlines/PEpline.html> 24/7
 Or call (800) 537-1046. (801) 538-6096 or (800) FON-AIDS 8-5 M-F (hospital clinicians may receive 24/7 help with PEP counseling by calling 1-888-448-4911)

The Laboratory must report the test results of the source patient testing to the EMS Agency/Employer Contact person listed above.

* The EMS Agency/Employer must submit the Employer's First Report of Injury/Illness (Form 122) when this form is completed by an EMS Provider.



Official Form 350 Revised 8/2012

State of Utah * Labor Commission * Division of Industrial Accidents

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