

INFECTIOUS EXPOSURE FORM
(This **MUST** be attached to an accident-injury report)

Name: _____ S.S. #: _____

Department: _____ Division: _____

Suspected or Confirmed Disease: _____

Date of Exposure: _____ Time: _____ Type of Incident (Motor Vehicle Accident,
Fire, etc.): _____

Source Individual Information : Source known? (circle one) – YES / NO

Name: _____ DOB : _____

S.S. #: _____ Address: _____

Phone #: _____

What were you exposed to?

Blood _____ Tears _____ Urine _____ Saliva _____

Vomit _____ Sputum _____ Sweat _____

Other _____

Body Fluid contact: Percutaneous (through the skin) _____ Needlestick _____

Other _____

What part of your body became exposed?

Mucous-Membrane _____ Eye _____ Nose _____ Mouth _____

Cutaneous _____ Specify where _____

Did you have any open cuts, sores, or rashes that became exposed? _____ Where? _____

Extent of protection:

Gloves _____ Mask _____ Coveralls _____ Glasses _____

Bunker Pants _____ Bunker Coat _____ Boots _____ Helmet _____

Face Shield _____ Self-contained breathing apparatus _____

Name of witness to your exposure: _____

Your Signature: _____ Date: _____