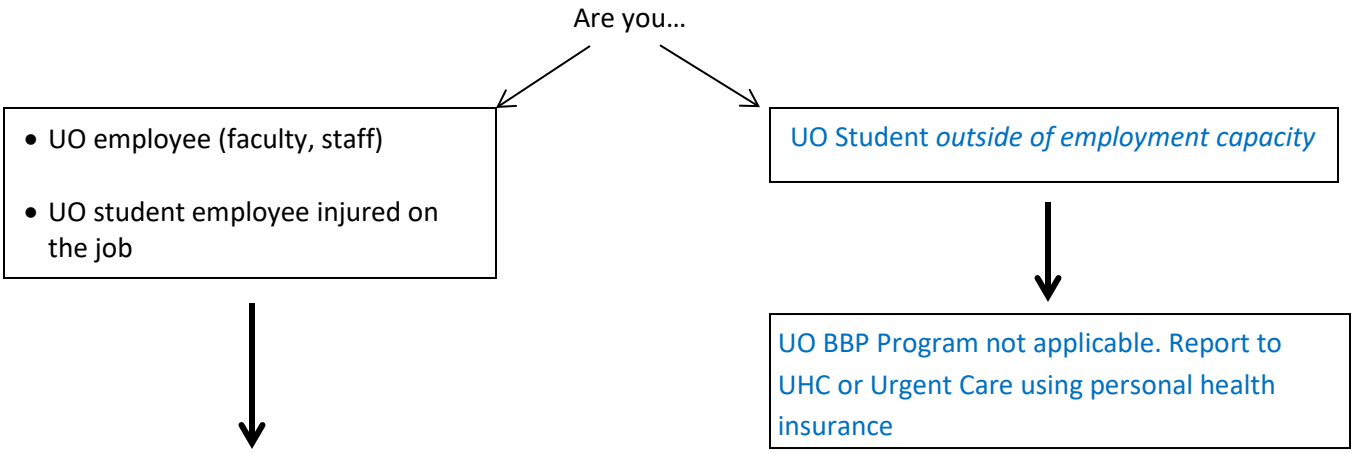
HAD A POTENTIAL BLOODBORNE PATHOGENS EXPOSURE?



Determine if a bloodborne pathogens exposure has occurred:

An **Exposure Incident** means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral (skin piercing) contact with someone else's blood or other potentially infectious materials (*OPIM*) that results from the performance of your work duties.

"**OPIM**" includes the following human body fluids:

- Semen
- Vaginal secretions
- Synovial (joint) fluid
- Pleural fluid
- Pericardial fluid
- Peritoneal fluid
- Amniotic fluid
- Saliva *in dental procedures*
- Any body fluid that is visibly contaminated with blood
- All body fluids in situations where it is difficult or impossible to differentiate between body fluids

Note: OPIM does not cover **vomit** or **saliva**. Saliva falls under OPIM only during dental procedures.

If you are not sure, handle the incident as an exposure until it is found not to be by medical evaluation.

IF YOU HAVE HAD AN EXPOSURE, FOLLOW INSTRUCTIONS AND FORMS IN THE PAGES BELOW.

UNIVERSITY OF OREGON

Bloodborne Pathogen Post-Exposure Instructions

*The instructions below apply to **UO employees** and **student employees** only.*

1. Determine first if an exposure to bloodborne pathogens has actually occurred. An **Exposure Incident** means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral (skin piercing) contact with blood or other potentially infectious materials (OPIM) that results from the performance of an employee's duties.

   "**OPIM**" includes the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva *during dental procedures*, any bodily fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. The following are not considered OPIM: urine, feces, vomit, and saliva outside of dental procedures.

   If you are not sure, handle the incident as an exposure until it is found not to be by medical evaluation.

2. Obtain the **Bloodborne Pathogens Post Exposure Packet,** available in hard copy in RED envelopes or online at: http://safety.uoregon.edu/bloodborne-pathogens. Complete the following forms. If a supervisor is not available to sign the forms, proceed with medical evaluation and the supervisor signature will be obtained later.
   - *BBP Post Exposure Form (fill out page 1 only)*
   - *Workplace Injury Report*
   - *SAIF Workers Compensation Claim Form (801)*

3. If the identity of the blood source for the exposure is known and is available, please inquire if that person would be willing to have his/her blood taken and tested for HIV and Hepatitis B infectivity. If the source agrees, request the source go to a healthcare practitioner for blood testing. DO NOT COERCE THE SOURCE IN ANY WAY TO CONSENT TO TESTING. SOURCE INDIVIDUALS DO NOT HAVE TO CONSENT TO TESTING.

4. Immediately or as soon as feasible, the exposed employee should be seen by a healthcare practitioner. Proceed to an emergency clinic. Student employees may also report to the University Health Center.

5. Transportation: If the employee is unable to transport him/herself or does not have private transportation to a medical facility, contact the UO Police Department at (541) 346-2919 to request transportation assistance.
   All forms need to go with the employee to the physician. The healthcare practitioner must complete page 2 of the BBP Post Exposure Form.

6. After forms are complete, send them to:

   Email: workinjury@uoregon.edu
   Fax: 541-346-7008
   Mail: 1260 University of Oregon, Eugene, OR 97403-1260

References:
UO Exposure Control Plan: http://safety.uoregon.edu/bloodborne-pathogens
Oregon OAR 437, Div. 2, Sub. Z: http://www.cbs.state.or.us/external/osha/pdf/rules/division_2/div2z-1030-bloodborne.pdf 2/7/2019

UNIVERSITY OF OREGON

WORKPLACE INJURY OR ILLNESS REPORT

Safety and Risk Services
1260 University of Oregon
1715 Franklin Blvd., Suite 2A

Phone: 541-346-3192
Fax: 541-346-7008
workinjury@uoregon.edu

Instructions: To be completed by employee with a lead staff member, supervisor or manager **WITHIN 24 HOURS** of when employee reports a work-related injury, illness, or near miss. **Complete ALL sections**, do not leave any blanks.

Department _____ Date of Report _____

Date of Incident or Illness _____ Time of Incident or Illness _____ a.m. ☐ p.m. ☐

Employee Information:

Employee Name _____
Last First MI

Employee ID# _____ Birth Date _____ Position Title _____

Employee Category ◯ Regular, full-time ◯ Regular, part-time ◯ Temporary UO ◯ Temporary Agency ◯ Student Worker ◯ Volunteer

Working Days ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S Working Hours _____

Injury Information:

Nature of Injury or Illness

☐ Burn ☐ Inflammation/irritation
☐ Bruise ☐ Scratches/abrasions
☐ Cut ☐ Sprain/strain
☐ No Injury ☐ Other _____

Body Part Affected _____
☐ Left ☐ Right ☐ Both

Treatment

☐ Received 1st aid
☐ Will be seeking medical treatment
☐ Received medical treatment
(to file a workers' compensation claim complete 801 form)
☐ Hospital transport*
☐ Fatality*
☐ No treatment
☐ Other _____

Work Status

☐ Left work early
☐ Missed work, dates: _____
☐ No missed work

Cause of Injury or Illness

☐ Burned by: _____
☐ Cut by: _____
☐ Contact with: _____
☐ Struck by: _____

Fall/Slip/Trip	Sprain/Strain	☐ Other
☐ Different level	☐ Lifting	_____
☐ Same level	☐ Bending/squatting	_____
☐ Floor condition	☐ Holding/carrying	_____
☐ Weather condition	☐ Pushing/pulling	_____
☐ Over object	☐ Reaching	
☐ On sidewalk/path	☐ Repetitive motion	
☐ On stairs	☐ Stairs	
☐ Footwear	☐ Twisting/turning	
☐ Rushing	☐ Walking	

Blood**

Was blood present? ◯ Yes ◯ No

If yes, was anyone exposed to blood? ◯ Yes** ◯ No

**If an employee was exposed to another person's blood or bodily fluids, please refer to exposure procedures at safety.uoregon.edu/bloodborne-pathogens

*If fatality or hospital transport, call Safety and Risk Services **immediately** at 541-346-3192.

Incident Details:	
Specific Site of Incident or Illness (i.e. building, room)	
Task/Activity at Time of Incident or Illness	
Witness(es) (name and contact information)	

Describe Incident or Illness
List the sequence of events; what happened and why:

_____

_____

_____

_____

Root Causes:

Identify factors that may have contributed to or caused incident or illness (check all that apply):

Management
- ☐ Safety procedures need review
- ☐ Training needed

Employee:
- ☐ Excessive force (sudden onset)
- ☐ Overexertion (developed over time)
- ☐ Repetitive motion
- ☐ Rushing
- ☐ Awkward posture
- ☐ Eyes not on task
- ☐ Mind not on task
- ☐ Balance or traction
- ☐ Grip
- ☐ Assistance was needed with task
- ☐ Cellphone in use
- ☐ Headphones/ earbuds in use

Environment
- ☐ Building conditions
- ☐ Chemicals
- ☐ Lighting
- ☐ Weather
- ☐ Caused by a 3rd party, name: _____

Equipment
- ☐ Improper use
- ☐ Proper tool not available or not used
- ☐ PPE needs to be reviewed
- ☐ Tool/equipment in need of repair, describe:

_____

_____

Other/Explain:

_____

_____

_____

Recommendations:

What can be done to prevent this incident or illness from happening again?

Explain: _____

_____

Who will follow up? _____ **Date to be completed:** _____

Signatures: *By signing below, I certify that this information is true and correct to the best of my knowledge.*

	Print Name	Signature	Date	Phone
Employee				
Lead Worker/ Manager				

Return this form to Safety and Risk Services **WITHIN 24 HOURS** of notice of incident or illness FAX: 541-346-7008 or email workinjury@uoregon.edu

saifcorporation
400 High St. SE, Salem, OR 97312

For SAIF Customer Use
Area _____ _____ _____
Dept. _____
Shift _____ CC _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

TO: SAFETY & RISK SERVICES
FAX: 541.346.7008 or EMAIL
workinjury@uoregon.edu

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness:	2. Date you left work:	3. Time you began work on day of injury: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S	**DEPT USE:** Emp
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.		Ins
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right			9. Check here if you have more than one job: ☐	Occ
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Nat
				Part
				Ev
				Src
				2src

Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

11. Your legal name:	12. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	13. Birthdate:	14. Gender: ☐ M ☐ F
15. Your mailing address, city, state and zip:			16. Home phone:
17. Social Security no. (see back*): **DO NOT PROVIDE SS#**	18. Occupation:		19. Work phone:
20. Names of witnesses:			

21. Name and phone number of health insurance company:	22. Name and address of health care provider who treated you for the injury or illness you are now reporting:
23. Have you previously injured this body part? ☐ Yes ☐ No	
24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No	
25. Were you treated in the emergency room? ☐ Yes ☐ No	

26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Businesss Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

27. Worker signature:	28. Completed by (please print):	29. Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name: University of Oregon	31. Phone: (541) 346-2907	32. FEIN: 464727800
33. If worker leasing company, list client business name:		34. Client FEIN:
35. Address of principal place of business (not P.O. Box): 1715 Franklin Blvd, Suite 2A, Eugene OR 97403		36. Insurance policy no.: 854636
37. Street address from which worker is/was supervised:	ZIP:	38. Nature of business in which worker is/was supervised: Education
39. Address where event occurred:		
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		41. Class code:
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No	44. OSHA 300 log case no:

45. Date employer knew of claim:	46. Worker's wage per hour $	47. Date worker hired:	48. If fatal, date of death
49. Return-to-work status: Not returned ☐	☐ Regular Date:	☐ Modified Date:	50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
51. Employer signature:	52. Name and title (please print):		53. Date:

801
X801 11/2020 UO

OSHA requirements: On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.

801

RESET PRINT

A guide for workers recently hurt on the job

The following information is provided by SAIF Corporation at the request of the Workers' Compensation Division

saifcorporation
400 High St. SE, Salem, OR 97312

How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- SAIF Corporation or your employer should be able to answer your questions. Call SAIF Corporation at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

  Ombudsman for Injured Workers:

  An advocate for injured workers

  Toll-free: 800.927.1271

  Email: oiw.questions@state.or.us

  Workers' Compensation Compliance Section

  Toll-free: 800.452.0288

  Email: workcomp.questions@state.or.us

* **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (01/10/DCBS/WCD/WEB) for distribution with X801 SAIF Corporation 1/10

UNIVERSITY OF OREGON

Bloodborne Pathogen Post-Exposure Form

If you have been exposed to another individual's blood or other potentially infectious material (OPIM), please complete page 1 of this form and give it to the health practitioner to complete page 2. ***All blanks must be completed.***

Name: _____ **Social Security # (required)**[1]**:**_____

Date of Exposure: _____ **UO Department**: _____

Please describe the job duties you were performing when the exposure occurred:[2]

Please describe how the exposure occurred:[3]

Please indicate the type of exposure:[3] ☐ Needlestick ☐ Cut/wound ☐ Splash to eye/mucous membrane
☐ Splash to non-intact skin ☐ Other (please describe): _____

Please list the type and brand of device involved in the incident[4]**:** _____

Have you been vaccinated against Hepatitis B (HBV)?[5] ◯ Yes ◯ No ◯ Don't Know
If yes, was the vaccination series completed? ◯ Yes ◯ No ◯ Don't Know
If yes, please provide date(s) of vaccination (if known): _____ _____ _____

By Oregon law you have the right to a confidential medical evaluation. At that time you may consent to baseline blood collection without giving consent for Human Immunodeficiency Virus (HIV) testing. The blood sample will be preserved for at least 90 days, during which time you may elect to have the baseline blood sample tested for HIV.[6]

Do you consent to baseline blood collection? ◯ Yes ◯ No **Do you consent to HIV testing?** ◯ Yes ◯ No

****

Do you know the identity of the person(s) to whose blood/body fluid you were exposed? ◯ Yes ◯ No

If yes, *please request that the person who is the source of the blood/body fluid see a medical practitioner for bloodborne pathogen testing*[6] and provide the following information:

Person's name(s):[7] _____

Person's contact information: _____

Is this person willing to be tested for HIV, HBV or other bloodborne pathogens?[7] ◯ Yes ◯ No ◯ Didn't ask
If not asked, please state reason: _____

Is this person already known to be infected with HIV/HBV?[8] ◯ Yes ◯ No ◯ Didn't ask

_____ _____

Signature of Exposed Person Signature of Supervisor

Health Care Professional's Written Opinion

TO BE COMPLETED BY EVALUATING MEDICAL PROFESSIONAL

1. Is a hepatitis B vaccination indicated for the potentially exposed person[9]? ☐ Yes ☐No
2. Has the potentially exposed person received this vaccination[9]? ☐ Yes ☐No
3. Has the potentially exposed person been informed of the results of this evaluation[10]? ☐ Yes ☐No
4. Has the potentially exposed person been counseled regarding the options of HIV/HBV testing[11]? ☐ Yes ☐No
5. Has the potentially exposed person been told about any medical conditions resulting from exposure to blood or other potentially infectious materials that requires further evaluation or treatment[10]? ☐ Yes ☐No

Please note: All other findings or diagnoses shall remain confidential and should not be noted on this form.[12]

- This document should be maintained in accordance with 29 CFR 1910.1020.[13]

_____ _____

Health Practitioner's Signature Printed Name of Healthcare Practitioner

Results of Source Testing[14]:

_____

_____

Oregon OSHA requires that the above information be returned to the employer and provided to the employee within 15 days of the evaluation.[15]

Please send form to:

Safety & Risk Services
Attn: Biological Safety Officer
1260 University of Oregon
Eugene, OR 97403-1260
EHSinfo@uoregon.edu

[1] OAR Ch. 437, Div. 2/Z, 1910.1030 (h)(1)(ii)(A)
[2] OAR Ch. 437, Div. 2/Z, 1910.1030(f)(4)(ii)(B)
[3] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(3)(i); (f)(4)(ii)(C)
[4] OAR Ch. 437, Div. 2/Z, 1910.1030 (h)(5)(i)(A)
[5] OAR Ch. 437, Div. 2/Z, 1910.1030(h)(1)(ii)(B)
[6] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(3)(iii)(B)
[7] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(3)(ii)(A)
[8] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(3)(ii)(B)
[9] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(5)(i)
[10] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(5)(ii)
[11] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(3)(v)
[12] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(5)(iii)
[13] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(6); (h)(1)(i)
[14] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(4)(D)
[15] OAR Ch. 437, Div. 2/Z, 1910.1030 (f)(5)

This form is required by OAR Ch. 437, Div. 2/Z, 1910.1030 and will be kept in employee's confidential medical file at employment site.