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

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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
hallieh@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.