



ACCIDENT-INJURY OCCUPATIONAL OCCURRENCE REPORT

This report/evaluation must be filled out when any employee exposure incident occurs. The employee must receive a copy of this form and any other written information/opinion from the evaluating Healthcare Professional within 15 working days of the completion of the evaluation.

SECTION I: Employee/Incident Information (filled out by employee)

Employee Name: _____ SS#: _____

Date of Occurrence: _____ Time: _____ am/pm Location: _____

Reported to Supervisor: _____ Accident/Injury Report Date Completed: _____

Exposure Occurred by: _____ Eye _____ Mouth _____ Nose _____ Non-intact skin (wound/sore)
(route)

Other: _____

Details of Occurrence: _____

I _____ have been instructed by _____

_____, to seek medical treatment for an exposure

Supervisor or person suggesting medical treatment

Incident received while working for LADD

____ Yes I would like medical treatment _____ No I do not wish to seek medical treatment at this time

Employee Signature

Date

Supervisor Signature

Date

Witness Signature

Date

Employee Name: _____

Exposure Incident Evaluation

SECTION II: Blood borne Pathogen Exposure (to be filled out only if blood borne exposure occurred)

Source Individual: _____ HBV Status: _____ (if known) HIV Status: _____ (if known)

If the HBV/HIV status of the source individual is unknown, then LADD will attempt to gain authorization from the guardian for testing if requested by the employee. The employee is held responsible to confidentiality of the source individual's name and testing results. If any information is disclosed, the employee is held personally responsible for federal and state fines/incarceration.

Employee Consent for Baseline Testing

I understand and agree with the information contained in this Occupational Occurrence Report form. I understand I have the option of having my blood collected for testing of the HIV/HBV serological status. The blood sample can be taken and preserved for at least 90 days if I am unsure if I want to be tested at this time.
(please initial your choice below)

_____ I am requesting testing for HIV/HBV serological status.

_____ I **decline** testing for HIV/HBV serological status.

_____ I am unsure at this time and would like my blood sample held for 90 days.

Employee Signature

Date

SECTION III: Medical Examination and Consultation (to be filled out by Physician/Clinic)

(Attached is a copy of the Employee's Job Duties and Personal Protective Equipment List for review)

Employee received HBV series? YES / NO Dates of Series: _____ Initiated _____ 2nd Shot _____ 3rd Shot

Seroconversion: Hepatitis B-surface Antibody:(result) _____ Date: _____

No responders: 4th shot: _____ 5th shot _____ Seroconversion: (result) _____ Date: _____

Any recommended limitations upon the employee's use of Personal Protective Equipment? _____

Results of Medical Evaluation including any medical conditions resulting from exposure & recommendations:

WE MAKE THE DIFFERENCE

Follow-up necessary: YES / NO

If yes, Date: _____

Time: _____

Post Exposure Prophylaxis medically necessary: YES / NO

Signature of Health Care Professional

Date

Print Name

Clinic Name/Address

SECTION IV: Review (to be reviewed by both the employee and LADD)

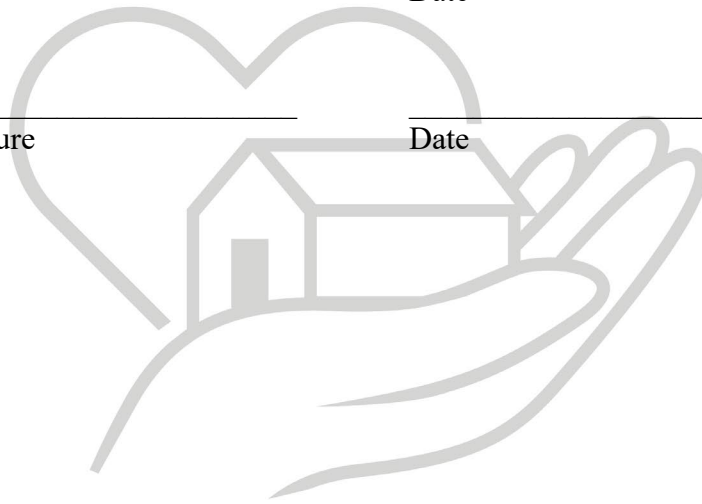
Any further counseling, evaluating, follow-up needed: _____

Employee Signature

Date

LADD Management Signature

Date



LADD

WE MAKE THE DIFFERENCE