Living Alternatives for the Developmentally Disabled, Inc.
L.A.D.D., Inc.

ACCIDENT-INJURY OCCUPATIONAL OCCURRENCE REPORT

Exposure Incident Evaluation

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: (route) ____ Eye ____Mouth ____Nose ____Non-intact skin (wound/sore)
____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 L.A.D.D., Inc.

____ 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

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

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

If the HBV/HIV status of the source individual is unknown, then L.A.D.D., Inc. 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:

_____

_____

_____

_____

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 L.A.D.D., Inc.)

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

_____ _____

Employee Signature Date

_____ _____

L.A.D.D., Inc. Management Signature Date