WESTPORT EMS / PD / FD
BLOODBORNE / AIRBORNE EXPOSURE REPORT

Name____ D.O.B. ___________________________
SS # _____________________________ Department___________________________
Title___________________________ Supervisor_________________________
Phone: (H) _______________________ (W) ___________________ (Cell) _____________________

INCIDENT

Exposure Date ____/____/____ Day of Week _______________ Exposure Time _________ am/pm

☐ Supervisor notified Name of Supervisor: ___________________________

ROUTE OF EXPOSURE

☐ Inhalation *Substance if known _______________________________
☐ Puncture: *Device/Make/Model/Brand _____________________________ *Needle gauge ________
☐ Laceration *Device (if applicable) ______________________
☐ Non-intact skin
☐ Mucosal Inoculation circle: eye / oral mucosa

* Required information by OSHA.

TYPE OF BODY FLUID

☐ Blood
☐ Urine/Feces/Mucous with visible blood
☐ Wound drainage
☐ Synovial fluid
☐ Vaginal secretions
☐ Cerebrospinal fluid
☐ Pleural fluid
☐ Pericardial fluid
☐ Amniotic fluid
☐ Other _______________

CIRCUMSTANCES

☐ Drawing Blood
☐ Inserting IV catheter
☐ Removing IV catheter
☐ During Needle Disposal
☐ Recapping Sharp
☐
☐ Scratched
☐ Splashed
☐ Exposed Sharp in Trash/Linen
☐ Exposed Sharp on Hard Surface
☐ Passing/Receiving Sharps
☐ Other: ___________________________

Person's Description of the Exposure____
____
____
____
____

Employee Signature: _____________________________________ Date: _______________
Reviewed by Supervisor: __________________________________ Date: _______________

Received/reviewed by Infection Control Officer _____________ Date: _______________

(use reverse side for follow-up)