Appendix B: Report of Exposure to Blood or OPIM

An exposure incident is defined by the OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030) as a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral (skin-piercing wound) contact with blood or other potentially infectious materials that results from the performance of an employee's duties. These materials include any bodily fluid containing visible blood, semen, vaginal secretions, fluids surrounding internal organs, unfixed human organs or tissues, and cultures containing HIV, HBV, or HCV.

Any employee so exposed must be referred to a healthcare professional for post-exposure care and counseling. Use this form and the Campuswide Exposure Control Plan to ensure post-exposure follow-up and care. Please direct questions to DRS at 217-333-2755.

EXPOSED EMPLOYEE

1. Wash and treat the exposed area. Use soap for skin; use only water for eyes, nose, or mouth.

2. Please provide the following information to the best of your knowledge.

Name:_____ Title:_____ UIN: _____

Home Address:_____ Home Phone: (_____)_____

City:_____ State:_____ Zip:_____ Work Phone: (_____)_____

Exposure Date and Time:___/___/:_____ ***AM/PM*** Exposure Location (Bldg/Rm): _____

Specify what you were exposed to (if possible): _____

The material came in contact with my:

[ ] right/left / both eye(s) [ ] nose [ ] mouth [ ] cut / scratched / punctured skin

If a sharp was involved, what type was it, include brand/model: _____

Describe employee duties as they relate to this exposure incident: _____

Describe how the exposure occurred. _____

PPE worn at the time: **[ ] gloves [ ] protective clothing [ ] face protection [ ] protective eyewear [ ] no PPE**

Immediately after the exposure:

I washed the exposed area thoroughly. **[ ] Yes [ ] No** I reported the exposure to my supervisor. **[ ] Yes [ ] No**

Have you been vaccinated against the hepatitis B virus? **[ ] Yes [ ] No**

Signature of Exposed Employee:_____ **Date:** _____

3. Give the completed report to your supervisor so they can fill out the next section.

4. Promptly report to the healthcare professional referred by your supervisor.

SUPERVISOR

1. Confirm that the employee has washed the exposed area and has completed their portion of this form.

2. Provide the following information. If you have questions, contact your PI or responsible person.

Your Name:_____ Title:_____ Phone: (_____)_____

On____/____/____ at_____ ***AM/PM***, the above-named employee reported this exposure to me.

Has the employee received a complete series of hepatitis B vaccinations? **[ ] Yes [ ] No**

Date the employee last received training in Occupational Exposure to Bloodborne Pathogens:____/____/_____ or

Date the employee last received training in Safe Handling of Human materials:____/____/_____

Has the employee signed a Declination of HBV Vaccination Form? **[ ] Yes [ ] No**

Can the identity of the source individual be confirmed? *(If yes, complete step 5.)* **[ ] Yes [ ] No**

The employee will seek follow-up care with the following:

[ ] Carle Occupational Medicine (217) 383-3077

[ ] Carle Emergency (217) 383-3313

[ ] Carle Convenient Care

[ ] Safeworks Illinois (217) 356-6150

[ ] OSF Emergency (217) 337-2131

[ ] OSF Urgent Care

[ ] Employee's physician

Signature of Supervisor:_____ **Date:** _____

3. Fill out the campus unit section on the following page and photocopy this form for your unit's records.

4. Send the original form to the healthcare professional.

5. If known, complete the Source Individual Identification Form.

Report of Exposure to Blood or Other Potentially Infectious Materials

HEALTHCARE PROFESSIONAL

1. Please provide the following information after completing your evaluation of the exposed employee.

Your Name:_____ Title:_____ Phone: (_____)_____

On____/____/_____ at_____ : _____ ***AM/PM***, the above-named employee reported this exposure to me:

The employee has been given the **[ ] 1st [ ] 2nd if necessary [ ] 3rd** vaccination in the hepatitis B series as part of post-exposure care. Remaining vaccinations (if applicable) should be arranged through the employee's unit.

I have evaluated and treated the employee in accordance with U.S. Public Health Service recommendations current at this date. I have informed the employee of the results of my medical evaluation and provided the employee information regarding necessary precautions, further medical evaluations and/or treatment, and potential illnesses that might result from the exposure. All other medical information regarding this exposure incident is confidential and will not be reported to the employer.

Signature of Healthcare Professional:_____ **Date:** _____

2. Photocopy this completed form and send the copy to the campus unit using the address in the section below.

3. Retain the original file in the employee's treatment record.

CAMPUS UNIT

Unit Name:_____ PI or responsible person /Title: _____

Unit Address *(incl. mail code):*_____ M/C-_____

Responsible person Work Phone: (_____)_____ Unit Emergency Phone: (_____)_____

On____/____/_____, this unit received a completed copy of this form from the healthcare professional listed above.

We provided a copy to the exposed employee on_____/_____/_____ and placed a copy in our unit records.

Signature of PI/Unit Representative:_____ **Date:**_____

Send (1) one copy of the completed form to each of the following:

- Division of Research Safety, 101 S. Gregory St., Room 102, Urbana, IL 61801 (M/C 225) or email to DRS-BBP@illinois.edu
- Office of Claims Management, 100 Trade Center Dr., Suite 103, Champaign, IL 61820 (M/C 686)

Appendix C: Occupational Exposure to BBP Source Individual Identification

SUPERVISOR: *Please complete this form to the best of your knowledge if a source individual can be identified in an exposure incident involving human blood or other potentially infectious materials (OPIM). Transmit this form as soon as possible to the occupational medicine department that is treating the exposed employee (phone and fax numbers are provided). For questions, contact your responsible person or call the Division of Research Safety at (217) 333-2755.*

CAMPUS UNIT

Unit Name:_____ PI or responsible person /Title: _____

Unit Address *(incl. mail code):*_____ M/C-_____

Responsible person Work Phone:_____ Unit Emergency Phone: _____

EXPOSED EMPLOYEE

Name:_____ Title:_____ UIN:_____

Date of Exposure:____/____/_____ Time:_____:_____ ***AM/PM*** Location (Bldg & Rm #): _____

CONFIDENTIALITY STATEMENT

The State of Illinois "AIDS Confidentiality Act" (410 ILCS 305) and 77 Ill. Adm. Code 697 (AIDS Confidentiality and Testing Code) provide for confidentiality of persons who are tested for HIV infection. The following provisions generally apply:

- No person may order an HIV test without first receiving informed consent (written or verbal) of the subject of the test or the subject's legally authorized representative*.
- Any person upon whom an HIV test is performed shall have the right to request anonymity and to provide informed consent (written or verbal) by using a coded system that does not link individual identity with the request or the result except when informed consent is not required by law.
- No person may disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of such a test, in a manner that permits identification of the subject of the test.

*Specific exceptions (e.g., healthcare workers, firefighters, police officers, etc.) to each of these provisions exist and may apply in some cases involving occupational exposure to blood or OPIM. Please refer to the Exposure Control Plan for this information.

Occupational Exposure to Bloodborne Pathogens
Source Individual Identification

SOURCE INDIVIDUAL

The human blood or other potentially infectious material involved in the exposure came from the following individual:

Name:_____ Work Phone: (_____)_____

Home Address: _____ Home Phone: (_____)_____

City:_____ State:_____ Zip Code:_____

Was the above-named source individual referred to a health care professional for testing? [ ] Yes [ ] No

- ***If yes, please specify the provider below.***

[ ] Carle Occupational Medicine (217) 383-3077

[ ] Carle Emergency (217) 383-3313 **[ ] OSF Emergency** (217) 337-2131

[ ] Carle Convenient Care **[ ] OSF Urgent Care**

[ ] Safeworks Illinois (217) 356-6150 **[ ] Personal physician**

- ***If no, please specify the reason below:***

[ ] Source individual declined to be tested

[ ] Above-named source individual cannot be located

Unit Representative Signature: _____

Unit Representative _____ **Date:**_____