COLUMBIA BASIN COLLEGE
BLOODBORNE PATHOGEN EMPLOYEE EXPOSURE INCIDENT REPORT

This form to be kept confidentially on file in the Human Resources Office.

Employee Name: _____

Department: _____

Location Exposure Occurred: _____
CBC Accident Report Form has been completed and submitted to Security: YES / NO

Type of Injury / Exposure	***Circle***	***Circle***	**Part of Body Injury/Exposure Location**	**Severity of Injury/Exposure** ***Please check box*.**
Skin exposure	Yes	No		❑ Incident Only – no first aid indicated
Mucous Membrane	Yes	No		❑ First Aid "In House" returned to duties.
Needle Stick:				❑ ER/HCP*, Evaluated, Treated, Released. Return to work.
Wound Bleeding	Yes	No		❑ ER/HCP, Evaluated, Treated, Released. Off work/school..
Injection of Blood	Yes	No		❑ Hospitalization.
Human Bite	Yes	No		*(Healthcare Professional)

Fluid Type: (Please Circle)

Blood Saliva Vomitus Urine Fecal Semen/Vaginal Other:_____

Non Bloodborne Pathogen: (Please Circle)

Puncture/Laceration Foreign Body Burn Dermatitis Irritations Respiratory Other (explain)

Have you ever been treated for Bloodborne Pathogen Exposure in the past?

- ❑ **YES (If Yes, please explain).**
- ❑ **NO**

Have you attended a safety orientation and/or annual update? YES / NO

EMPLOYEES: I have been informed of my right to file a Workers' Compensation claim for this injury/illness. If I decline to file a claim at this time, I may still do so for up to one year from the date of injury, (RCW 51.28.050) and up to two years from the date I have written notice from a physician of the existence of an occupational disease (RCW 51.28.055).
As a responsible employee, I have made sure that all of the above information is correct and true to the best of my knowledge and I hereby agree to comply with all attendance, performance, safety Workers' Compensation and other applicable CBC policies and procedures while recovering from any on the job injury or illness.

Employee Signature: _____ **Date:** _____

Incident Manager – Verification of Completion of Post-Exposure Protocol

Print Name: _____

Signature: _____ **Date:**_____