



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, *Chancellor*

DIVISION OF HUMAN RESOURCES
OFFICE OF OCCUPATIONAL SAFETY & HEALTH (OOSH)
65 Court Street -Room 706
Brooklyn, New York 11201

CONFIDENTIAL

EMPLOYEE EXPOSURE INCIDENT REPORT-PART I

Use this form to document routes and circumstances of a Bloodborne Pathogens exposure incident. As stipulated by the Bloodborne Pathogens Standard, 29 CFR 1910.1030, this form and related documentation will be kept on file by the New York City Department of Education for the length of employment and 30 years This form and related documentation will remain confidential. Personal identifying information will be released with your consent only.

PART I-TO BE FILLED OUT BY EXPOSED EMPLOYEE

ANSWER ALL QUESTIONS. BE SPECIFIC. PLEASE PRINT.	
RECORD NUMBER _____ - _____ - _____ / _____ <small>(BUILDING CODE #-YY-MM-DD/CASE #) EX: (123K-04-09-01/01)</small>	DATE COMPLETED:
EXPOSED EMPLOYEE NAME:	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
HOME TELEPHONE:	OTHER CONTACT NUMBER:
WORK SITE NAME/ ADDRESS:	
WORK SITE DOE CODE # (EXAMPLE 555K):	WORK TELEPHONE:
EMPLOYEE HEPATITIS B VACCINATION STATUS:	
<input type="checkbox"/> DOSE #1	DATE:
<input type="checkbox"/> DOSE #2	DATE:
<input type="checkbox"/> DOSE #3	DATE:
<input type="checkbox"/> NONE	<input type="checkbox"/> DECLINED DATE:
DATE OF EXPOSURE:	TIME OF EXPOSURE: <input type="checkbox"/> AM <input type="checkbox"/> PM
LOCATION OF INCIDENT	
NATURE OF INCIDENT:	
DESCRIBE TASK(S) IN PROCESS WHEN EXPOSURE OCCURRED:	



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PART I-TO BE FILLED OUT BY EXPOSED EMPLOYEE

WERE YOU WEARING PERSONAL PROTECTIVE EQUIPMENT (PPE)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, PLEASE DESCRIBE:	
DID PPE FAIL?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, EXPLAIN HOW:	
WERE YOU EXPOSED TO BLOOD, BODY FLUIDS OR OTHER POTENTIALLY INFECTIOUS MATERIALS?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
WHAT BODY FLUID(S) WERE YOU EXPOSED TO?	
WHAT PART(S) OF YOUR BODY WAS EXPOSED?	
ESTIMATE THE SIZE OR THE AREA OF YOU BODY THAT WAS EXPOSED?	
HOW LONG DID THE EXPOSURE LAST?	
DID A FOREIGN BODY (NEEDLE, NAIL, AUTO PART, DENTAL WIRES, ETC.) PENETRATE YOUR BODY?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, IDENTIFY OBJECT:	
WAS FLUID INJECTED INTO YOUR BODY?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, IDENTIFY FLUID:	HOW MUCH?
IDENTIFICATION OF SOURCE INDIVIDUAL(S):	
NAME / AFFILIATION #1:	NAME/ AFFILIATION #2:

EMPLOYEE'S SIGNATURE

PRINCIPAL'S SIGNATURE:

DATE

DATE



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EMPLOYEE EXPOSURE INCIDENT REPORT-PART II

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PART II- TO BE FILLED OUT BY SITE ADMINISTRATOR

ANSWER ALL QUESTIONS. BE SPECIFIC. PLEASE PRINT.	
RECORD NUMBER _____ - _____ - _____ / _____ <small>(BUILDING CODE #-YY-MM-DD/CASE #) EX: (123K-04-09-01/01)</small>	DATE COMPLETED:
EMPLOYEE NAME:	
HOME TELEPHONE:	OTHER CONTACT NUMBER:
WORK SITE NAME/ LOCATION:	
WORK SITE DOE CODE# (EXAMPLE 555K):	WORK TELEPHONE:
IS A COMPREHENSIVE ACCIDENT REPORT DETAILING THIS INCIDENT ON FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS AN SH 900 AND RELATED DOCUMENTS DETAILING THIS INCIDENT ON FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE	
IF NO OR N/A, EXPLAIN:	
COMPLETED COPY FORWARDED TO :	
<input type="checkbox"/> Regional Representative (enter name and address):	<input type="checkbox"/> New York City Department Of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Phone #: (718) 935-2319 Fax #: (718) 935-4682

SITE ADMINISTRATOR'S SIGNATURE

PRINCIPAL'S SIGNATURE:

DATE

DATE



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EXPOSURE INCIDENT REPORT-COUNSELING-PART III

The standard requires that post-exposure counseling be given to employees following an exposure incident. Counseling should include USPHS recommendations for transmission and prevention of HIV. These recommendations include refraining from blood, semen, or organ donation; abstaining from sexual intercourse or using measures to prevent HIV transmission during sexual intercourse; and refraining from breast feeding infants during the follow-up period. In addition, counseling must be made available regardless of the employee's decision to accept serological testing.

PART III- TO BE COMPLETED BY HEALTH CARE PROFESSIONAL DESIGNATED TO COUNSEL EXPOSED EMPLOYEE

RECORD NUMBER _____ - _____ - _____ - _____ / _____ (BUILDING CODE #-YY-MM-DD/CASE #) EX: (123K-04-09-01/01)	
HEALTH CARE PROFESSIONAL NAME AND TITLE	
OFFICE LOCATION:	
TELEPHONE:	FAX NUMBER:
EXPOSED EMPLOYEE NAME AND TITLE:	
SOCIAL SECURITY NUMBER:	
HOME ADDRESS:	
HOME PHONE:	
JOB DESCRIPTION:	
DATE OF EXPOSURE:	DATE REPORTED:
FACILITY NAME:	
ADDRESS:	
EXACT LOCATION OF EXPOSURE:	
TYPE OF EXPOSURE:	
SOURCE OF INDIVIDUAL	
IMMEDIATE ACTION TAKEN:	
TREATMENT PROVIDED:	
RECOMMENDATION:	
REFERRAL:	
COMMENTS:	

HEALTH CARE PROFESSIONAL-COUNSELOR SIGNATURE: _____ DATE _____



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EMPLOYEE EXPOSURE INCIDENT REPORT-PART IV

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PART IV-TO BE FILLED OUT BY EXPOSED EMPLOYEE'S MEDICAL CARE PROVIDER

ANSWER ALL QUESTIONS. BE SPECIFIC. PLEASE PRINT.	
RECORD NUMBER _____ - _____ - _____ - _____ / _____ <small>(BUILDING CODE #-YY-MM-DD/CASE #) EX: (123K-04-09-01/01)</small>	DATE COMPLETED:
EXPOSED EMPLOYEE NAME:	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
HOME TELEPHONE:	OTHER CONTACT NUMBER:
WORK SITE NAME/ LOCATION:	
WORK SITE DOE CODE # (EXAMPLE 555K):	WORK TELEPHONE:
NAME/TITLE/ AFFILIATION:	
DID YOU TREAT THE PATIENT/EMPLOYEE DIRECTLY?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, SPECIFY TREATMENT REGIMEN:	
OTHER PERTINENT INFORMATION:	

MEDICAL CARE PROVIDER NAME

DATE

MEDICAL CARE PROVIDER SIGNATURE