NYC Department of Education

Joel Klein

Bloodborne Pathogens Standard

29 CFR 1910.1030

Sharps Injury Package

INSTRUCTIONS: Complete the forms in this package to report occupational injury with contaminated sharps.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Sharps Injury Report		
NAME OF FORM	PAGE	ACTION
Part 1 – Sharps Injury Report	1 – 2	1. Completed by employee 2. Employee receives a copy
Part 2 – Sharps Injury Report	3	1. Completed by Administrator 2. Employee receives a copy
Part 3 – Sharps Injury Report - Counseling	4	1. Completed by Health Care Professional Designated to Counsel Exposed Employee
Part 4 – Sharps Injury Report	5	1. Employee gives blank copy of this form to the physician 2. Completed by employee's medical provider and returned within 10 days unless employee completes the Declination Form
Employee Declination of Post-Exposure Evaluation		
Exposed Employee Declination to receive Medical Evaluation and Follow-up After an Exposure Incident	6	1. Completed by employee if refusing medical attention
Identification and Evaluation of Source Individual (if known)		
NAME	PAGE	ACTION
Part A – Identification and Evaluation of Source Individual	7	1. Completed by Site Administrator
Part B – Identification and Evaluation of Source Individual	8	1. Part A completed by Site Administrator 2. Part B completed by Medical Provider
Employee's Exposure follow-up Record		
NAME	PAGE	ACTION
Part A – Exposed Employee Follow-up Record	9	1. Completed by Employee
Part B – Employee's Exposure follow-up Record	10	1. Provide Employee with blank form to give to Medical Provider 2. Completed by Employee's Medical Provider
Exposure Incident Report Log	11	1. Completed and maintained by Site Administrator 2. Copy sent to OOSH

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Completed by Exposed Employee

Bloodborne Pathogens Standard

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Sharps Injury Report – Part 1

Please print all information

EMPLOYEE DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #"	Home Telephone #:

EMPLOYEE HEPATITIS B VACCINATION STATUS	
Have you received the HBV vaccine? ☐YES ☐ NO	Date Dose #1 Received:
If NO, Did you fill out an Employee Vaccination Form? ☐YES ☐ NO	Date Dose #2 Received:
	Date Dose #3 Received:

INCIDENT EXPOSURE	
Date of Exposure:	Time of Exposure: ☐ AM ☐ PM
Where Did The Incident Take Place?	
Where Did The Incident?	
Describe The Incident:	

INCIDENT EXPOSURE	
Check ☑ to Describe How The Exposure Occurred:	AFFECTED BODY PARTS Check ☑ all That apply
☐ During use of sharp	☐ Finger
☐ Disassembling	☐ Arm
☐ While preparing to dispose of sharp	☐ Hand
☐ Sharp left in an inappropriate place	☐ Leg
☐ Other (Specify)	☐ Other (Specify)

IDENTIFICATION OF SHARP INVOLVED (IF KNOWN)	
Type:	
Brand:	
Model:	

SUBMIT COMPLETED COPY TO:			
☐	ISC Safety and Health Liaison (enter name and address)	☐	New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

_____ _____

Employee Signature Principal's Signature

_____ _____

Date Date

This form and related documentation will remain confidential. Personal identifying information will be released with the employee's consent only.

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Completed by Site Administrator

Bloodborne Pathogens Standard

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Sharps Injury Report – Part 2

Please Print All Information

EMPLOYEE DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #"	Home Telephone #:

INCIDENT REPORTING
Is A Comprehensive Accident Report Detailing This Incident On file? ☐YES ☐ NO
Is An SH 900 and Related Documents Detailing this Incident On File? ☐YES ☐ NO ☐ NOT APPLICABLE
If NO, or N/A, explain:

SUBMIT COMPLETED COPY TO:	
ISC Safety and Health Liaison (enter name and address)	New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

_____
Site Administrator's Signature

_____
Principal's Signature

_____
Date

_____
Date

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Completed by Health Care Professional
Designated to Counsel Exposed Employee

Bloodborne Pathogens Standard

29 CFR 1910.1030

Sharps Injury Report – Part 3

NOTE - OSHA's Bloodborne Pathogens Standard cited as 29 CFR 1910.1030 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.

HEALTH CARE PROFESSIONAL	
Health Care Professional Name:	Title:
Office Location:	
Telephone:	Fax Number:
EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Home Address:	
Home Telephone:	Social Security #:
EXPOSURE INCIDENT	
Employee Job Description:	
Date of Exposure:	Date Exposure Reported:
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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Completed by Exposed Employee's Medical Care Provider

Bloodborne Pathogens Standard

29 CFR 1910.1030

Sharps Injury Report – Part 4

EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Date of Birth:	Social Security #:
Work Site Name:	Work Telephone:
MEDICAL CARE PROVIDER	
Health Care Professional Name:	Title:
Address:	
Telephone:	Fax Number:
MEDICAL CARE PROVIDER'S REPORT	
Did You Treat The Patient/Employee Directly? ☐YES ☐ NO	
If YES, Specify Treatment Regimen:	
Other Pertinent Information:	

_____ _____

Medical Care Provider's Signature Date

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 the employee's consent only.

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Completed by Exposed Employee
Declining Medical Evaluation and Follow-up

Bloodborne Pathogens Standard

29 CFR 1910.1030

Employee Declination of Post-Exposure Evaluation Form

I was exposed to blood and other potentially infectious body fluids at my worksite on _____. As a result of this incident, I have completed the required incident report and was advised by Administration to seek medical evaluation and follow up by a Physician or Health Care Provider immediately. I decline medical evaluation.

Employee's Last Name:	Employee's First Name:	
Job Title:	Social Security #:	
Work Site Name:		
Work Site Address:		
Region#:	District:	Work Telephone:

_____ _____
Exposed Employee Signature Date

_____ _____ _____
Site Administrator's Name Site Administrator's Signature Date

_____ _____ _____
Principal's Name Principal's Signature Date

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Completed by Site Administrator

Bloodborne Pathogens Standard

29 CFR 1910.1030

Identification and Evaluation of Source Individual - Part A

EXPOSED EMPLOYEE		
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #:	Job Title:
Work Site Name:	Work Telephone:	Home Telephone:
MEDICAL CARE PROVIDER		
Health Care Professional Name:	Affiliation:	
Address:		
Telephone:	Fax Number:	
INCIDENT INFORMATION		
Date of Incident:	Name or Record Number or Source Individual:	
Check ☑ the most appropriate:		
☐	Blood or Body Fluid Splashed into Mucus Membrane or non-Intact skin	
☐	Contaminated Needle Stick Injury	
☐	Other:	
Signature	Date	

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

DO NOT RETURN THESE FORMS TO THE SCHOOL. FORMS MUST REMAIN IN EXPOSED EMPLOYEE MEDICAL FILE

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Part 1 - Completed by Site Administrator
Part 2 – Completed by Source Individual's Medical Provider

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Identification and Evaluation of Source Individual - Part B

Part 1

MEDICAL CARE PROVIDER	
Medical Care Provider's Name:	Affiliation:
Address:	
Telephone:	Fax Number:

Part 2

REPORT OF SOURCE INDIVIDUAL EVALUATION Return this report to the above named exposed employee's medical provider within 15 days of evaluation	
Testing of source Individual's Blood: ☐ Consent Obtained ☐ Consent Refused	
TEST RESULTS	
Check ☑ One	
☐	Evaluation of source individual evidenced to known exposure to bloodborne pathogens
☐	Evaluation of source individual evidenced possible exposure to bloodborne pathogens. Medical follow-up recommended
☐	Identification of source individual infeasible or prohibited by State or Local Law. State why:
Name/Affiliation of Person Completing This Report:	
Signature	Date

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

DO NOT RETURN THESE FORMS TO THE SCHOOL. FORMS MUST REMAIN IN EXPOSED EMPLOYEE MEDICAL FILE

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Part 1 - Completed by Exposed Employee

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Employee's Exposure Follow-Up Record - Part 1

Part 1

EXPOSED EMPLOYEE INFORMTION	
Exposed Employee Name:	Date Completed:
Work Site Name:	Work Site Address:
Job Title At Time of Exposure:	
Date of Exposure:	Time of Exposure:
SOURCE INDIVIDUAL FOLLOW-UP	
Name of Source Individual:	
Request Made To:	Date:
SUBMIT COMPLETED COPY TO:	
☐ ISC Safety and Health Liaison (enter name and address)	☐ New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

_____ Employee's Signature

_____ Principal's Signature

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Part 2 - Completed by Exposed Employee's Medical Care Provider

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Employee's Exposure Follow-Up Record - Part 2

EXPOSED EMPLOYEE	
Name/Affiliation:	
Employee's Health File Reviewed ☐YES ☐ NO	Date:
Blood Sampling/Testing Offered/Completed ☐YES ☐ NO	Date:
Vaccination Offered/Issued: ☐YES ☐ NO	Date:
Counseling Offered: ☐YES ☐ NO	

SOURCE INDIVIDUAL BLOOD TESTING
☐ Results made available to employee. Employee has been informed of medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation and treatment.
☐ Consent not obtained

SUBMIT COMPLETED COPY TO:	
☐ ISC Safety and Health (enter name and address)	☐ New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

_____ Medical Care Provider's Signature

_____ Employee's Signature

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Completed and Maintained by Site Administrator

Calendar Year:

Bloodborne Pathogens Standard – Sharps Injury Log

This form is required by OSHA's Bloodborne Pathogens Standard 1910.1030 and must be kept in the facility for 5 years. Failure to maintain this log can result in the Issuance of Notice of Violation and Order to Comply. Use this form to log injures from contaminated sharps. Information provided on this form must be recorded and maintained in such a manner as to protect the confidentiality of the injured employee. Forward completed form at the end of each calendar year to: The Office of Occupational Safety and Health, 65 Court Street, Room 706, Brooklyn, NY 11201.

Facility Name:	Principal's Name:
Facility Address:	Facility Phone:

#	DATE OF EXPOSURE	TYPE OF SHARP INVOLVED (IF KNOWN)	BRAND/MODEL OF SHARP INVOLVED	PLACE OF INCIDENT	TASKS BEING PERFORMED AT TIME OF INCIDENT	DESCRIPTION OF EXPSOURE
1.						
2.						
3.						
4.						
5.						