St. Clair County Community Mental Health Authority

Bloodborne Pathogen Exposure

Employee:_____
(Last Name) (First Name) (Initial)

Home Address:_____
(Street) (City/State) (Zip Code)

Division/Program:_____Title:_____

Date of Exposure:_____Time:_____AM _____PM

Location of Exposure:_____

Route of Exposure:_____

Circumstances Related to the Incident:_____

_____

_____

_____

_____

Source (Consumer/Staff):_____
(Last Name) (First Name) (Initial)

Address:_____
(Street) (City/State) (Zip Code)

Hepatitis or HIV Status:_____Positive_____Negative

Were environmental surfaces (tables, floor, etc.) contaminated? If yes, were they decontaminated according to procedures in Bloodborne Pathogens Exposure Control Plan?

☐ Yes ☐ No

_____ _____
Supervisor Signature Date

cc: Division Director
Safety Designee