BBP-1
EXPOSURE INCIDENT REPORT FORM

Employee Name _____
(please print)
Social Security # _____
Department _____
Date _____
Supervisor Name _____

Description of Incident: (be specific and include date, approximate time and place)
Use back of sheet if needed

_____

_____

_____

_____

_____

_____

Immediate Actions Taken: _____

_____

_____

Source of Blood or OPIMs (include name of source individual, if known): _____

_____

Personal Protective Equipment Worn: _____

Hepatitis B Vaccination Status: ___ declined vaccine ___complete ___1st shot ___2nd shot

Employee Signature _____ Date _____