

**BBP-1
EXPOSURE INCIDENT REPORT FORM**

Employee Name _____
(please print)
UIN# _____
Department _____
Date _____
Supervisor Name _____

Description of Incident: (be specific and include date, approximate time and place)

Immediate Actions Taken:

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

Personal Protective Equipment Worn: _____

Hepatitis B Vaccination Status (declination form offered through training course):

Declined vaccine Complete 1st shot 2nd shot

Employee Signature _____ Date _____