



**California State University, Bakersfield
Bloodborne Pathogen Exposure Report**

Use this form to document **all incidents involving blood or potentially infectious material** that may have resulted in personnel exposure. **When in doubt, use this form and report the incident as soon as possible to the immediate supervisor**, but no later than the end of the work shift.

This form and a copy of the Supervisors Report of Injury should be provided to the attending physician. The physician should send the completed form to the **Office of Human Resources** to be filed with the employees' occupational medical records.

Name: _____ Location Where Injury Occurred: _____

Date of Injury: _____ Time of Injury: _____ Type of Injury: _____

INCIDENT DESCRIPTION: See attached Supervisor's Report of Injury.

Has the employee previously received the full Hepatitis B Vaccination series? Yes No

For Medical Provider: In compliance with California Code of Regulations, Title 8, Section 5193, an exposure incident refers to an eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties. The medical provider is to examine the reported facts of the incident and determine whether sufficient exposure potential exists to warrant prophylaxis, and the components of any prescribed treatment.

Did an exposure occur? Yes No

When an exposure has occurred, CSUB shall make the necessary immune serum globulin and/or Hepatitis B vaccination series immediately available to the exposed employee when medically indicated. The prophylaxes shall be made available as soon as possible, but in no event later **than** 24 hours after the incident occurred.

If the employee refuses recommended medical prophylaxes, please indicate below and have the employee sign as documentation of declination and forward this completed form to the address above or FAX to 661-654-2299.

Prophylaxis Recommended: Yes No
 Hepatitis B ISG Other_____

Prophylaxis Provided: Yes No Declined treatment

Signature declining treatment_____ Date: _____

Physicians Name: _____ Facility: _____

Physicians Signature: _____ Date: _____

Telephone Number: _____