Scotts Valley Fire District

Infectious Exposure Form

Exposed Members Name _____ Rank:_____

Incident #:_____PCR # _____Home Phone: _____

Shift: _____Station: _____Supervisor_____

Name of Source Patient: _____ Sex: _____

Age: _____ Address: _____ Phone: _____

Suspected or Confirmed Disease: _____

Transported to: _____Transported by: _____

Date of Exposure: _____Time of Exposure:_____

Type of Incident:(auto accident, trauma): _____
_____
_____

What were you exposed to? Blood _____Tears _____Feces _____Urine _____

Saliva_____Vomitus _____Sputum_____Sweat_____other_____

What part(s) of your body became exposed? Be specific: _____
_____
_____

Did you have any open cuts, sores, or rashes that became exposed? Be specific_____
_____
_____

How did the exposure occur? Be specific: _____
_____
_____

What infectious control garments and equipment were utilized?_____
_____
_____

Did you seek medical attention? Yes _____ No_____ Date: _____

Where?_____

Contact Infection Control Officer: Date _____Time:_____

Employee's Signature: _____Date:_____

Supervisor's Signature: _____Date: _____

Copies to: □ Workers Comp □ Safety Officer □ Employee