PERRY BOARD OF EDUCATION	DIAF-E1

COMMUNICABLE DISEASE RISK EXPOSURE REPORT

The filing of this report and all information entered on it are to be held in strictest confidence in conformance with 63 O.S. Supp. 1988, Section 1-502.1, et seq.

EXPOSED WORKER SECTION (Please Print)

1. Employee Name:_____ 2. Birthdate: _____
(Last) (First) (Middle Initial) Mo/Day/Yr
3. Profession/Job Title:_____ 4. Employer/Company Name: _____
5. Work Site/Telephone:_____ Tel. Ext. #: _____
(Site) (Street Address)
6. Home Address/Telephone:_____ (_____) _____
(Street) (City) (Zip) AC Telephone #
7. Supervisor's Name/Telephone:_____ Tel. Ext. #: _____
(Last) (First)
8. Date of Exposure: (Mo/Day/Yr) _____/_____/_____ 9. Time of Exposure:_____ AM or PM (Circle One)
10. Detailed Description of Potential Exposure: _____
_____
_____
11. Exposed Worker _____ has _____ has not completed the full series of Hepatitis B vaccine.
12. Source Person's Name: _____
(Last) (First) (Middle Initial)
13. Disposition of Source Person (include address):
_____
_____

TO BE COMPLETED BY EMPLOYER'S DESIGNEE

The employer agrees to be responsible for all reasonable charges incurred in the disposition of this risk exposure incident.

Employer Designee Reviewing Form:

14. Name _____ 15. _____ 16. _____/_____/_____
(Please Print) Signature (Mo/Day/Yr)

TO BE COMPLETED BY THE EMPLOYER'S PHYSICIAN

_____ In my professional judgment, this was a parenteral, permucosal, or significantly cutaneous exposure to blood or other body fluids which has the potential for transmission of a communicable disease such as Hepatitis B, HIV, or meningococcus. Post exposure evaluation procedures and counseling should be provided. The employee has been told about any medical conditions resulting from exposure that requires further treatment.

_____ This incident does not constitute an exposure under the OSHA standard. NOTE: If this exposure does not warrant medical follow-up, please return the form to the Employer's Designee and indicate to that individual why it does not need follow-up.

_____ The employee has received or is beginning the Hepatitis B vaccination series.

17. _____ 18. _____ 19. _____/_____/_____
Physician's Name (Please Print) (Physician's Signature) (Mo/Day/Yr)