



Whittier College Post-Exposure Response Form Biohazards

Today's Date:	Incident Report #:
Employee/Student Name:	Employee/Student ID#:
Employee Job Title:	
Principle Investigator Name:	
Room Number or location of incident:	
Biohazard (Agent) to which you were exposed:	
Date and Time of exposure:	
Duration of Exposure in minutes:	

Type or Route of Exposure	Check all that apply
Type 1: Splash to mucous membrane: <input type="radio"/> Skin <input type="radio"/> Eyes	<input type="radio"/> Nose <input type="radio"/> Mouth <input type="radio"/> Other _____
Type 2: Type of non- intact skin exposure (other than a needlestick) <input type="radio"/> Puncture, laceration, abrasion <input type="radio"/> Open sore, wound, lesion <input type="radio"/> Eczema, skin rash <input type="radio"/> Other	(i.e. – condition of skin when exposed; not symptoms after exposure) Location on body: Location on body: Location on body: Location on body:
Type 3: Needlestick <input type="radio"/> Contaminated <input type="radio"/> Non-contaminated	Location on body: Location on body:
Type 4: Type of intact skin and/or clothing exposure <input type="radio"/> Wet drops/spray on clothing (no skin contact) <input type="radio"/> Fluids soaked through clothing (skin contact)	<input type="radio"/> Dried blood or solid contact on clothing <input type="radio"/> Dried blood or solid contact with skin

Brief Description of the exposure circumstances:

Every exposed individual must fill out this form and in addition follow the following course of action depending on the type of exposure for the affected individual.

Approved medical facility: HealthFirst Medical Group – South, 13440 E. Imperial Highway, Santa Fe Springs, CA 90670 (562) 926-3440

Type 1 or Type 2 exposure: Exposed individual should seek immediate medical care at an approved medical facility. Then, visit Human Resources (HR) so they can assist you in completing the Human Resources First Report of injury form for worker's compensation and HR will then record this on OSHA 300 log.

Type 3 (needlestick) exposure:

Contaminated Needle: Exposed individual should seek immediate medical care at an approved medical facility. Then, visit Human Resources (HR) so they can assist you in completing the Human Resources First Report of injury form for worker's compensation and HR will then record this on OSHA 300 log.

Non-contaminated Needle: Then, visit Human Resources (HR) so they can assist you in completing the Human Resources First Report of injury form for worker's compensation (no exposure) and HR will then record this on OSHA 300 log.

Type 4 exposure:

Contact with mucous membrane including open wound on skin or needlestick (similar to Type 1,2, or 3 exposure but on intact skin): Exposed individual should seek immediate medical care at an approved medical facility. Then, visit Human Resources (HR) so they can assist you in completing the Human Resources First Report of injury form for worker's compensation and HR will then record this on OSHA 300 log.

Contact with clothing only: Exposed individual must change contaminated clothes and wash up immediately.

Post-incident Investigation

PPE used by exposed individual at the time of exposure (check all that apply):

<input type="checkbox"/> Medical gloves	<input type="checkbox"/> Goggles	<input type="checkbox"/> Helmet
<input type="checkbox"/> Hot/cold gloves (non-plastic)	<input type="checkbox"/> Eye and face shield	<input type="checkbox"/> Fluid resistant gown or suit
<input type="checkbox"/> Labcoat	<input type="checkbox"/> Facemask	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Respirator	

Engineering controls (i.e. fume hood, biosafety cabinet, etc.) in use at the time of exposure (explain):

Procedures being performed at the time of exposure (explain):

Was the individual trained and authorized to perform the procedures?

- Yes
- No

THIS SECTION TO BE FILLED OUT BY THE BIOSAFETY OFFICER

Actions Taken

- Individual counseled/retrained on (date) _____
- Individual retrained by _____
- Individual received medical care on (date) _____
- Medical Facility name and address _____
- Individual refused medical treatment on (date) _____

- Was there follow-up care beyond initial visit? _____ Date if applicable _____
- Work practice was changed and/or Exposure Control plan was amended? (date) _____
- Healthcare professional's report was received on the following date: _____
- Copy of the healthcare professional's report was given to individual on (date) _____
- Investigative report closed and filed on the following date: _____

Person completing this report:

Print name: _____ Title: _____

Signature: _____ Date: _____