Bloodborne Pathogen Exposure Incident
Health Care Professionals

Part A. Opinion for Hepatitis B Vaccination

Date of visit:

Employee Name:
Last Name First Name MI

Social Security Number:

Blood Taken: _____ Y/N Date Taken:

Written/Oral Consent given: _____ Y/N

HBV Test: _____ Y/N

HIV Test: _____ Y/N

_____ Y/N Hepatitis B vaccination **IS** indicated for this employee; vaccination received.

_____ Y/N hepatitis B vaccination **IS** indicated for this employee; vaccination not received.

_____ Y/N Hepatitis B vaccination is **NOT** indicated for this employee; vaccination not received.

Part B. Opinion Concerning Post-Exposure Evaluation and Follow-up

_____ Y/N Employee informed of his HBV/HIV test results and evaluation;

_____ Y/N The employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Health Care Provider's Signature Date

Dear Health Care Professional:

So that Northwest Youth Corps can comply with applicable regulations, please return this original form to us via the employee in a sealed envelope immediately upon completion of your evaluation. Please retain a copy for your file. We will provide the employee with a copy within 15 days of your evaluation. The original form will be retained in the employee's confidential medical records file on a permanent basis.

Northwest Youth Corps
2621 Augusta St.
Eugene, OR 97403

Bloodborne Pathogens Exposure Report

To be completed by NYC Staff

Employee Name:
Last Name First Name MI

Social Security Number:

Describe the exposure incident:

Description of duties (specific activities) at the time of the exposure incident:

Which employee body parts were exposed, to what fluids were those parts exposed, and how were they exposed:

Attach copies of any available and relevant historical medical records maintained by the employer on the exposed person including HBV vaccination status.

Injured (source) person.

Name of source person:

Social Security Number:

Description of Injury:

Name of ambulance service, hospital, and doctor who treated source person.

Indicate any test results from injured (source) person as to Hepatitis B (HBV) and AIDS (HIV); attach test reports or testing organization if available:

Signature _____ Date

Bloodborne Pathogens
Employee Refusal of Vaccination

Employee: _____ Date: _____
Last First Middle

Social Security Number: _____

Date of Exposure: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself. However, I decline Hepatitis B vaccination at this time.

I understand that by declining this vaccine, I may be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____

Date: _____

Witness: _____

Witness Signature: _____ Date: _____

Note: This form must be attached to Exposure Report.