

St. Clair County Community Mental Health
Bloodborne Pathogen Exposure

Employee: _____
(Last Name) (First Name) (Initial)

Home Address: _____
(Street) (City/State) (Zip Code)

Division/Program: _____ Title: _____

Date of Exposure: _____ Time: _____ AM _____ PM

Location of Exposure: _____

Route of Exposure: _____

Circumstances Related to the Incident: _____

Source (Consumer/Staff): _____ (Last Name) (First Name) (Initial)
Address: _____ (Street) (City/State) (Zip Code)
Hepatitis or HIV Status: _____ Positive _____ Negative

Were environmental surfaces (tables, floor, etc.) contaminated? If yes, were they decontaminated according to procedures in Bloodborne Pathogens Exposure Control Plan?

Yes No

Supervisor Signature Date

cc: Division Director
Safety Designee