COMMUNITY COLLEGE OF PHILADELPHIA
BLOODBORNE PATHOGEN EXPOSURE INCIDENT REPORT

Injured Party's Name: _____

Date, Time and Place of Incident: _____

Employee/Student ID Number: _____

DOB: _____

Address: _____

Home Phone Number: _____

Emergency Contact: _____

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Source Client's Name: _____

Address: _____

Home Phone Number: _____

Emergency Contact: _____

Witness(es)

Name _____ Phone _____

Name _____ Phone _____

Description of Incident (Please be specific: Who, what, when where and why).

_____

_____

_____

_____

_____

Instructor/Supervisor: _____

Print Signature:

Security Guard: _____

Print Signature

Instructions:

- Administer First Aid
- Notify Security at 215-751-8111
- Complete **BOTH SIDES** of this Form
- For Employee Incident – send a copy of this report to Human Resources
- For Student Incident – send a copy to VP Student Affairs, Dean and Human Resources
- Inform Injured/Exposed individual to report to WorkNet or an Emergency Room
- If incident occurs at an Off-site Campus give a copy of the Incident Report to the Student/Faculty/Staff

If injured party refuses care, have them sign the Treatment Waiver that is on the back of this report.

Read and sign the appropriate statement.

Accept Treatment _____

I have experienced an Exposure to Bloodborne Pathogens at _____. (time and place) I understand that this exposure may have put me at risk for exposure to HIV, Hepatitis B, Hepatitis C and other bloodborne pathogens. I have been informed of the need for immediate
evaluation for Post-Exposure Prophylaxis for HIV. I am aware that a Licensed Medical Doctor must see me within 2 hours of my exposure (needlestick, cut, splash, etc.) for this evaluation. I plan to be seen by _____ at _____ (time and date). I have also been informed that I should be evaluated in an Emergency Room if it is after 5:00 pm.
Print Name of Injured/Exposed Individual _____
Signature of Injured/Exposed Individual _____
Signature of Witness _____
Date _____

Refuse Care _____

TREATMENT WAIVER

I have experienced an Exposure to Bloodborne Pathogens at _____ (time and place) _____. I understand that this exposure may have put me at risk for exposure to HIV, Hepatitis B, Hepatitis C and other bloodborne pathogens. I have been informed of the need for immediate evaluation for Post-Exposure Prophylaxis for HIV. I am aware that a Licensed Medical Doctor must see me within 2 hours of my exposure (needlestick, cut, splash, etc.) for this evaluation. I have also been informed that I should be evaluated in an Emergency Room if my doctor cannot see me within 2 hours. I acknowledge that I have chosen not to follow this advice and assume full responsibility for the possible deleterious effects of my actions, which are against the Community College of Philadelphia's Policy for Exposures to Bloodborne Pathogens.

Print Name of Injured/Exposed Individual: _____

Signature Injured/Exposed Individual:_____

Signature of Witness:_____

Date:_____