



Exposure Incident Investigation Form

Use this form to report any blood-borne pathogen exposure incidents. Fax completed form to the Biosafety Office at 348-3574.

SECTION I: ALL BBP EXPOSURE INCIDENTS

Date of Report: _____

Name: _____ Date of Exposure Incident: _____

Phone: (W) _____ (H) _____

Hepatitis B Status: vaccine received, date: _____ vaccine declined

Location of Occurrence: On campus Off Campus

Building and Room Number: _____

Potentially Infectious Materials Involved: _____

(Blood, body fluid, etc)

Source: _____ Telephone: _____

(Individual or Supplier)

If source from individual, health status of individual known: **yes** **no**

Describe the task being performed at the time of the exposure:

Identify the route of exposure (skin, eye, mucous membrane, etc):

List PPE being used at the time of exposure:

To whom has the incident been reported?

1. Name: _____ Dept: _____ Phone #: _____

2. Name: _____ Dept: _____ Phone #: _____

Witnesses present (P.T.O. for witness statement):

1. Name: _____

Phone # (W/H): _____

2. Name: _____

Phone # (W/H): _____

SECTION II: FIU EMPLOYEES ONLY

Social Security #: _____

Job Title: _____

Injured on the job? **yes** **no** Date reported to supervisor: _____

Medical treatment provided? **yes** **no** If yes, where: _____

Has claim or injury report been filed with FIU Worker's Comp: **yes** **no**

If not, please contact the Worker's Comp Program Manager at 348-7960

Form completed by:

Name: _____

Title: _____

Signature: _____