

City of Gloucester

Exposure Report Form

Employee Name

Date of Incident

Address of incident

Time of incident

Run number (if app.)

Type of run (if app.)

Infectious Disease Exposure

Patient address

Name of patient

Patient phone number

Time of exposure

Exposure substance(s) - Blood

Route of exposure -

Tears

Feces

Urine

Vomit

Sputum

Sweat

Saliva

Other

What part(s) of your body was exposed?

Hazardous Material Exposure

Name of material exposed to, if known

Select state

Route of exposure -

Length of Exposure

Were you decontaminated?

Any adverse effects?

When and Where?

Summary

Describe incident, treatment received, and any possible future safeguards.

Sign and date below: Electronic signature is the legal equivalent of a handwritten signature

Date: