West Virginia School of Osteopathic Medicine

Bloodborne Pathogen Exposure Incident Report Form

Full Name:

Full Address:

Phone Number: Date Reported:

Date of Exposure:

Potentially infectious materials involved (blood, body fluids, cell line, etc.):

Source (from individual, supplier, exposure to waste, etc.):

If source is from “individual”, please provide the health status of the individual if known:

Describe the task being performed at time of exposure:

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

Signature: _____