



# West Virginia School of Osteopathic Medicine

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## Bloodborne Pathogen Exposure

### Incident Report Form

*This form must be completed in full and submitted to Human Resources within 24 hours of the incident.*

*This form should accompany the WVSOM Incident Report Form.*

Full Name: \_\_\_\_\_

Date Reported: \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### Exposure Incident:

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.):

Has the employee received the Hepatitis B Vaccine:     Yes             No

If Yes, Please provide vaccination dates:

Dose #1: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose #2: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose #3: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature  
Print Name:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature  
Print Name:

\_\_\_\_\_  
Date

Name of person completing the report (if other than the injured person): \_\_\_\_\_

Received by the Office of Human Resources: \_\_\_\_\_

Information sent to Worker's Compensation: \_\_\_\_\_

Signature of Human Resources Representative/Title