Please Note: This report is intended to be used by Emergency Service Organizations for internal use only. It is not an acceptable VFIS Claims form and therefore should not be submitted to VFIS.

Infectious Exposure Form

Exposed Member's Name: _____ Position: _____

Soc. Sec. #: _____ Home Phone: _____

Field Inc. #: _____ Shift: _____ Company: _____

Name of Patient: _____ Sex: _____

Age: _____ Address: _____

Suspected or Confirmed Disease: _____

Transported to: _____

Transported by: _____

Date of Exposure: _____ Time of Exposure: _____

Type of Incident (auto accident, trauma): _____

Type of protective equipment utilized: _____

What where you exposed to:

Blood _____ Tears _____ Feces _____ Urine _____ Saliva _____

Vomitus _____ Sputum _____ Sweat _____ Other _____

What part(s) of your body became exposed? Be specific: _____

_____

_____

_____

_____

Did you have any open cuts, sores, or rashes that became exposed? Be specific: _____

_____

_____

How did exposure occur? Be specific: _____

_____

_____

Did you seek medical attention? _____Yes _____No

Where? _____ Date: _____

Contact Infection Control Supervisor: Date_____ Time: _____

Supervisor's Signature: _____ Date: _____

Member's Signature: _____ Date: _____

Infection Control Supervisor's Report

Medical facility notified? Yes _____ No _____

If Yes:

Name of Facility: _____ Date: _____

Address of Facility: _____

Name of Facility Contact: _____

Confirmed Exposure: _____

Member notified? Yes _____ No _____

Member's Signature: _____ Date: _____

Medical Follow-Up Action:

_____

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

Infection Control Supervisor's Signature: _____ Date: _____