Exposure Reporting Procedure

If you are the employee exposed:

1. Thoroughly wash the affected area with an anti-bacterial soap as soon as possible.
2. Notify your Captain of the exposure.
3. Complete State of Utah form 350, the Emergency Medical Provider Exposure Report Form. The source patient info **must** be completed.
4. Complete State of Utah form 122, the Workers Compensation Employer's First Report of Injury or Illness.
5. Try to convince the source patient to be transported and agree to a blood draw.
6. If the source patient does not agree to transport or a blood draw gather the source patients name, address, home telephone number, and social security number for contact in the future if required.
7. Insure that the receiving medical facility is aware of the situation.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

You do **not** have to have blood drawn. Your baseline has been established by your departmental physical.

If you are the Captain of an exposed employee:

1. Insure that all protective measures are taken. The employee has washed the affected area, etc.
2. Notify your Battalion Chief of the exposure.
3. Insure that the exposed employee has completed State of Utah form 350, the Emergency Medical Provider Exposure Report Form, as completely as possible. The source patient info **must** be completed.
4. Insure that the exposed employee has completed the State of Utah form 122, the Workers Compensation Employer's First Report of Injury or Illness.
5. Complete the U.F.A.'s Supervisor's Report of Injury or Illness form.
6. Try to convince the source patient to be transported and agree to a blood draw.
7. If the source patient does not agree to transport or a blood draw gather the source patients name, address, home telephone number, and social security number for contact in the future if required.
8. Insure that the receiving medical facility is aware of the situation.
9. The incident must be logged in the station log. The information must reflect who was involved, what the nature of the incident was (including the case number), the circumstances leading to the exposure, the details of the exposure itself,

immediate actions taken to remediate the situation, and the final disposition of the incident.

10. In the event that the exposed person is incapacitated, it is your responsibility to ensure the proper forms are completed.

The exposed employee does **not** need a blood draw after an exposure. The employee's baseline has been established by the department physical.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

Copies of all completed forms are to be kept in a secure location at the station.

If you are the Battalion Chief of an exposed person:

1. Insure that all protective measures have been taken. The employee has washed the affected area, etc.
2. Notify the Safety Officer of the Exposure.
3. Insure that the exposed employee's Captain has had the State of Utah form 350, Emergency Medical Provider Exposure Report Form, completed to the fullest extent possible.
4. Insure that the exposed employee's Captain has had the State of Utah for 122, Worker' Compensation Employer's Fire Report of Injury or Illness, completed to the fullest extent possible.
5. Review the U.F.A.'s Supervisor's Report of Injury or Illness form that has been completed by the Captain. Additional comments may be added, however insure that your comments are kept separate from the Captain's and insure it is clearly annotation whose comments are whose.
6. Insure that the source patient has agreed to and been transported for a blood draw.
7. If the source patient does not agree to transport or a blood draw gather the source patients name, address, home telephone number, and social security number for contact in the future if required.
8. Insure that the employee's Captain has insured the received medical facility is aware of the situation.
9. Insure that the proper completed forms are forwarded to the Safety Officer.
10. In he event that the employee's Captain is incapacitated, it is your responsibility to ensure that the proper forms and notifications are completed.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

The exposed employee does **not** need a blood draw after an exposure. The employee's baseline has been established by the department physical.

Copies of all completed forms are to be kept at a secure location at the Battalion Chief's office.

All of the Hospitals in the valley should be familiar with the new exposure reporting procedure. If there are any questions please contact the Safety Officer as soon as possible.

Form 350 8/05

State of Utah _ Labor Commission Division of Industrial Accidents
160 East 300 South, 3rd Floor – P O Box 146610, Salt Lake City, UT 84114-6610
(801)530-6800 – (800)530-5090 – Fax (801)530-6804

UNIFIED FIRE AUTHORITY

Emergency Medical Service Provider Exposure Report Form

Complete this form to document exposure to blood and/or other body fluids. Most unprotected exposures do not result in an infection, however, some people can be exposed to a disease and not have any symptoms of illness. It is important that you document any significant exposure incident.

Significant Exposure -- EMS provider information

Exposed Provider, use your last initial, first initial, last 4 digits of Social. Security number for ID# ex. (ba6789) ID #________

Employee Name: ______________________________ DOB ___/___/___ Sex ______
(Last) (First) (M) M or F

Home Phone ________________ Work Phone ________________ Employer / Agency *Unified Fire Authority*____

Contact person at Employment / Agency Safety Officer or Personnel Chief Contact Phone ______ 801-743-~~7200~~ 7212 ________

Date______________ Incident #________________

Mechanism of exposure: (check all that apply)

	Body Fluid Exposure
	Blood
	Birth fluids
	Pericardial fluids
	Pleural fluid
	Synovial fluid
	Cerebrospinal fluid
	Semen
	Vaginal secretions

	Other body fluid w/ blood
	Saliva
	Urine
	Feces
	Pus
	Sputum
	Other:

	How were you exposed?
	Splash in eye
	Splash in mouth or nose
	Bite
	Puncture w/ hollow-bore needle
	Puncture / cut w/ other sharp implement
	Open wound
	Rash / dermatitis
	Abrasion

What protective equipment were you using at the time of exposure? (check all that apply)

	Bag-valve-mask		One way resuscitation mouthpiece		Paper gown
	Gloves		N-95 Mask		Other:
	Eye protection		Surgical mask (less than N-95 rating)		Comments:

Source of Significant Exposure – Source Patient Information

Source Patient Name______________________________ Phone# _____-__________
(Last) (First) (M)

Source Patient Address______________________________(Street address) DOB _____/______/________

______________________________(City, State, Zip) Sex M_____ F_______

☐I hereby give my permission to the facility named below to draw and test my blood for any or all of the following, ☐ HIV antibody, ☐HBV/Surface Antigen and ☐HCV antibody. I understand that the results of this testing are private information and will be confidential.
☐ I refuse to have my blood drawn and tested. I understand that a court order may be pursued to require me to have blood testing done.

Source Patient (or responsible) Signature ______________________________ Date ____/_____/______.

Receiving Facility/Testing Laboratory

Receiving Facility ______________________________ Date Specimen(s) were obtained _____/_____/_____

Testing Laboratory______________________________Date Specimen(s) were submitted_____/_____/_____
Did patient expire ☐ Yes ☐ No Was the patient under the jurisdiction of the State Department of Corrections (prisoner or parolee)? ☐ Yes ☐ No

Name of Person submitting report ______________________________

Title ________________ Phone number______________ Date Report was submitted ____/____/________

The Laboratory must report the test results of the source patient testing to the EMS Agency/Employer Contact person listed above.
If onsite post exposure counseling is not available contact any of the following… http://www.ucsf.edu/hivcntr/Hotlines/PEPline.html 24/7
Or Call (800) 537-1046, (801) 538-6096 or (800) FON-AIDS 8-5 M-F (hospital clinicians may receive 24/7 help with PEP counseling by calling 1-888-448-4911)

* The EMS Agency/Employer must submit the Employer's First Report of Injury/Illness (Form 122) when this form is completed by an EMS Provider.

FORM 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610 SALT LAKE CITY, UTAH 84114-6610

GENERAL

EMPLOYER (Name & Address Incl. Zip)
Unified Fire Authority
3380 South 900 West
Salt Lake City, UT 84119

INDUSTRY CODE:

EMPLOYER FEIN: 75-3134967

CARRIER/ADMINISTRATOR CLAIM NUMBER:

OSHA LOG NUMBER:

REPORT PURPOSE CODE:

JURISDICTION:

JURISDICTION CLAIM NUMBER:

INSURED REPORT NUMBER:

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT):

LOCATION #:

PHONE #: (801) 743-7200

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#):

POLICY PERIOD: TO

CHECK IF APPROPRIATE: ☐ SELF-INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
Travelers
Workers' Compensation Unit
PO Box 173762
Denver, CO 80217-3762
(800) 227-1538 Fax (877) 806-1781

CARRIER FEIN:

POLICY/SELF-INSURED NUMBER:

ADMINISTRATOR FEIN:

AGENT NAME AND CODE NUMBER:

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE):

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

DATE HIRED:

STATE OF HIRE:

ADDRESS (INCL ZIP):

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCE ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION / JOB TITLE:

EMPLOYMENT STATUS:

PHONE:

OF DEPENDENTS:

NCCI CLASS CODE:

RATE: PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

OF DAYS WORKED/WEEK:

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: ☐ AM ☐ PM

DATE OF INJURY/ILLNESS:

TIME OF OCCURRENCE: ☐ AM ☐ PM

LAST WORK DATE:

DATE EMPLOYER NOTIFIED:

DATE DISABILITY BEGAN:

CONTACT NAME/PHONE NUMBER:

TYPE OF INJURY / ILLNESS:

PART OF BODY AFFECTED:

DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY / ILLNESS CODE:

PART OF BODY AFFECTED CODE:

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

CAUSE OF INJURY CODE:

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

DATE RETURN(ED) TO WORK:

IF FATAL, GIVE DATE OF DEATH:

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS):

HOSPITAL (NAME & ADDRESS):

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR CLINIC/HOSP
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED > 24 HRS
- ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #):

DATE ADMINISTRATOR NOTIFIED:

DATE PREPARED:

PREPARER'S NAME & TITLE:

PHONE NUMBER:

SEE BACK FOR IMPORTANT INFORMATION

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SUPERVISOR'S REPORT OF INJURY OR ILLNESS

ALL ITEMS MUST BE ANSWERED FULLY

EMPLOYEE

WARNING: "WORKERS' COMPENSATION INSURANCE FRAUD IS A CRIME PUNISHABLE BY LAW."

Location (print) ________________ State ______ Department ______ Phone Number ________________

Employee Name ________________ Date of Birth ________________ Employee # ____

Address ________________ City ________________ State _____ Zip ____________

Social Security # ________________ Married: ☐ Yes ☐ No Sex: ☐ Male ☐ Female Age _______

Job Title ________________ Length of Service with Company _______ Years

Hourly Wage Rate $ ____________ Job Being Performed at Time of Injury ________________

Description of Incident: ________________________________

____

____

Release of Medical Information

I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and to LWP Claims Solutions, Inc., all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the Company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care provider, hospitals and clinics, insurance companies and workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original.

Employee Signature ________________________________ Date ________________

SUPERVISOR

INCIDENT DETAILS

Date of Incident ________________ Time of Incident ___________ ☐ AM ☐ PM Date Reported ________________

Shift: ☐ Graveyard ☐ Days ☐ Afternoon ☐ Other Was Employee on Overtime? ☐ Yes ☐ No Time Shift Commenced ______

Incident Location (specific area) ________________________________ On employer premises? ☐ Yes ☐ No

Witness(es) to Incident ________________________________

Did Employee lose time due to the injury? ☐ Yes ☐ No First Aid Given? ☐ Yes ☐ No

Date worker left work ____________ Time worker left work ___________ Date worker returned to work ____________

Complete if Applicable: **Medical Facility** ________________________ Doctor ________________________

(if Medical Attention is sought, complete State Form)

Follow up appointment scheduled? ☐ Yes ☐ No

Was time off authorized by the physician? ☐ Yes ☐ No If yes, how many days? _________

Treatment given ☐ Prescription ☐ Irrigation ☐ Sutures ☐ Tetanus Shot
☐ Brace ☐ Cast ☐ Removal of Foreign Object ☐ None
☐ Ace Bandage ☐ Other

PART OF BODY INJURED – MARK ALL THAT APPLY

☐ Head	☐ Arm R - L	☐ Trunk	☐ Hip R - L	☐ Foot R - L
☐ Face	☐ Elbow R - L	☐ Shoulder R - L	☐ Thigh R - L	☐ Toe - Identify
☐ Eye R - L	☐ Forearm R - L	☐ Chest	☐ Knee R - L	☐ Ribs R - L
☐ Nose	☐ Hand R - L	☐ Back: Lower-Upper	☐ Leg R - L	☐ Skin
☐ Neck	☐ Finger – Identify	☐ Abdomen	☐ Ankle R - L	☐ Other (*describe*)

SUPERVISOR

NATURE OF INJURY – MARK ALL THAT APPLY

- ☐ Abrasion
- ☐ Bruise-Crushed
- ☐ Laceration Cut
- ☐ Amputation
- ☐ Puncture
- ☐ Fracture-Dislocation
- ☐ Poisoning-Systemic
- ☐ Dermatitis
- ☐ Exposure-Chemical
- ☐ Hearing Loss
- ☐ Sprain
- ☐ Strain
- ☐ Inhalation
- ☐ Fatality
- ☐ Exposure-Heat/Cold
- ☐ Foreign Object
- ☐ Burn-Heat-Chemical
- ☐ Other (*describe*)

INVESTIGATION

Date of Investigation ____________ Person(s) Making Investigation ____________

Employee's Supervisor (print name)____________ Supervisor's Phone # ____________

Who was immediately in charge at the time of injury ____________

Was Employee Task Trained? ☐ Yes ☐ No If Yes, explain ____________

Were Safety Codes/Rules Violated? ☐ Yes ☐ No If Yes, explain ____________

Equipment Involved: Type ____________ Model No. ____________ Manufacturer ____________

CAUSE OF INJURY – MARK ALL THAT APPLY

- ☐ Body Motions
- ☐ Bldg/Structures
- ☐ Chemicals
- ☐ Infectious Agents
- ☐ Vehicles
- ☐ Hot/Cold Temperatures
- ☐ Conveyers
- ☐ Electrical – HV
- ☐ Electrical – LV
- ☐ Falling Objects
- ☐ Flame/Fire/Smoke
- ☐ Furniture/Fixtures
- ☐ Hand Tools–Non Power
- ☐ Hand Tools – Power
- ☐ Hoisting Apparatus
- ☐ Ladders
- ☐ Machines–Misc.
- ☐ Noise
- ☐ Particles
- ☐ Sharp Objects
- ☐ Slip/Trip/Fall
- ☐ Flying Objects
- ☐ Flash
- ☐ Other

CAUSE OF INCIDENT – MARK AND EXPLAIN ALL THAT APPLY

- ☐ Equipment Failure
- ☐ Lack of Attention
- ☐ Improper Material Handling
- ☐ Wet Slippery Uneven Surface
- ☐ Excessive Speed
- ☐ Procedure Failure
- ☐ Poor Housekeeping
- ☐ Fatigue
- ☐ Horseplay
- ☐ Other (explain)

ANALYSIS

Description of Incident: ____________

STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE – MARK AND EXPLAIN ALL THAT APPLY

- ☐ Reinstruction of Employee Involv ed
- ☐ Reminder Instruction of all Employees
- ☐ Personal Protective Equipment Required
- ☐ Formal Disciplinary Action
- ☐ Installation of Guard Device
- ☐ Counseling of Employee

Comments: ____________

Supervisor Signature____________ Date ____________