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Notification of Blood or Body Fluid Exposure - Page 1 of 3

Emergency Medical Services Provider

Indiana State Department of Health

State Form 51467 (9-03)

This form is to be completed by the exposed Emergency Medical Services Provider in compliance with IC 16-41-10-2.

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill-in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ⊗
- 4 Print capital letters only and numbers completely inside boxes:

A	2	C	3
---	---	---	---
- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY or MM/DD/YYYY
- 7 Time format: HHMM - 24 hour clock

SECTION 1: Information Regarding Emergency Medical Services Provider Exposed to Blood or Body Fluid

Last Name

First Name

MI

Telephone Number

Number & Street Address

City

State

Zip Code

County

_____/_____/_____
Date of Birth

Sex:
 Male Female

E-mail Address

Race (fill in the circle(s) that apply):

American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White

Ethnicity:

Hispanic or Latino
 Non-Hispanic

Employer

Address of Employer

City

State

Zip Code

Telephone Number

Fax Number

E-mail Address

SECTION 2: Exposure Information

Run Number (if applicable):

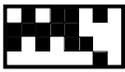
_____/_____/_____
Date

Time

Location (fill in the circle that applies):

Incident Site Ambulance Emergency Department Other

If Other, specify:



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SECTION 2: Exposure Information (Continued)

Person(s) whose blood or body fluid you were exposed to:

	/	/	
Name	Date of birth	<input type="radio"/> Unknown	

	/	/	
Name	Date of birth	<input type="radio"/> Unknown	

(add additional names on a separate sheet if necessary)

Fill in the circle(s) to indicate which fluid you were exposed to:

- Blood
 Saliva
 Semen
 Vaginal secretions
 Unable to identify body fluid
 Other

If Other, specify

Fill in the circle(s) that describe how the exposure occurred:

- Skin broken with a contaminated needle or object
 Eye, mouth, or other mucous membrane exposure
 Non-intact skin exposure
 Other, specify:

Comments and other pertinent information

SECTION 3: Submitting Completed Form

The Emergency Medical Services Provider must submit a copy of this report to **each** of the following:

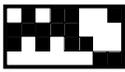
1. Employer's Medical Director (must be notified within 24 hours of exposure)

Name of Medical Director

Address

	-	
City	State	Zip Code

	/		/		
Date:					Time



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SECTION 3: Submitting Completed Form (Continued)

2. Emergency Department's Medical Director:

Name of Medical Director

Name of Medical Facility

Address

City

State

Zip Code

_____/_____/_____
Date

Time

3. Indiana State Department of Health
2 North Meridian Street, 5K
Indianapolis, IN 46204
FAX: 317-233-9271

_____/_____/_____
Date

SECTION 4: Exposure Follow-up Notification

Fill in the circle next to the physician you want to receive the results of the testing done in accordance with 16-41-10. The physician of your choice must inform you of the results of testing within 48 hours of receiving the results.

Exposed Emergency Medical Services Provider's Physician

Name

Address

City

State

Zip Code

Telephone Number

Fax Number

Employer's Medical Director (named on Page 2).

SECTION 5: Signature and Date

Signature of exposed Emergency Medical Services Provider

_____/_____/_____
Date