RM0013
Rev. 7/20

BLOODBORNE EXPOSURE INCIDENT REPORT

Risk Management Department
Lincoln Public Schools
(Use Blue or Black ink)

Phone: 402-436-1760
Fax: 402-458-3276

Employee Section:

Employee Name: _____ ID#: _____

Date of Birth: _____ LPS Start Date: _____ Date of Incident: _____ Time of Incident: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ LPS Email: _____

School: _____ Position: _____ Special Ed: ❑ Yes ❑ No

Did injury involve a student?: ❑ Yes ❑ No Student ID#/Name: _____ Special Ed. Student: ❑ Yes ❑ No

On the above date, the employee was involved in an incident (contact with blood or other potentially infectious material). The following information was obtained to assist in a medical evaluation of the incident:

1. How did contact with blood/body fluid occur?

A. Explain: _____

_____

B. Specific job duties being performed at time of exposure: _____

C. Body Part (check all that apply):

❑ Eyes	❑ Other mucous membrane	❑ Wrist	❑ Other _____
❑ Nose	❑ Non-intact skin (arm, leg, etc...)	❑ Arm	
❑ Mouth	❑ Needlestick, puncture, bite, scratch	❑ Leg	

2. Type of body fluid/material:

❑ Blood ❑ Other potentially infectious material; specify (ex. mucus, urine): _____

3. Estimated amount of blood/body fluid or description of amount: _____

(Non-Electronic) Employee Signature: *Date:*

Health Office Section:

5. Did handwashing and/or flushing of mucous membrane occur as soon as possible? ❑ Yes ❑ No

Comments: _____

6. Was personal protective equipment utilized? (If so, what type, e.g., gloves, face shield, etc.) ❑ Yes ❑ No

Comments: _____

7. Was clothing contaminated? If so, did appropriate disposal/laundering procedures occur? ❑ Yes ❑ No

Comments: _____

8. Severity of exposure:

A. Percutaneous (skin piercing) Depth of injury: _____ Was source fluid present at site of injury? ❑ Yes ❑ No

Comments: _____

B. Mucous membranes: Area covered: _____ Length of time of exposure: _____

Comments: _____

C. Non-intact skin Condition of skin: ❑ Fresh cuts (24 hrs.) ❑ Dermatitis ❑ Chapped ❑ Other _____

9. Employee has been referred to District designated medical provider for evaluation and follow up. ❑

10. Has employee been previously immunized to Hepatitis B? ❑ Yes ❑ No

11. Copies of documentation sent with employee to District Designated Treatment Facility?: ❑ Yes ❑ No

_____ _____

(Non-Electronic) Health Office Signature, if seen *Date:*

Risk Management Use Only

Send Completed Form to Risk Management Department • LPSDO • Box 14