

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/laundrying 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