Palm Harbor Fire Rescue
Infectious Exposure Form

Exposed member's name: _____ Rank:_____
Employee number: _____ Shift/Assignment: _____
Incident Number:_____
Incident Location:_____
Name of patient: _____Sex: _____Age: _____
Address: _____ _____ _____
Was source blood collected on the scene?: ☐ yes ☐ no
Suspected or confirmed disease: _____
Patient Transported to: _____
Patient Transported by: _____
Date of exposure: _____ Time of exposure:_____
Type of incident (e.g., auto accident, trauma): _____
What were you exposed to?
☐ Blood ☐Tears ☐Feces ☐Urine ☐Saliva ☐Vomitus ☐Sputum
If substance is other than blood, was blood visible in it? _____
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: _____
_____
_____
Was PPE was being worn at the time? ☐ yes ☐ no
Did you seek medical attention? ☐ yes ☐ no
If yes, where: _____Date: _____
Did you contact your infection control officer? ☐ yes ☐ no
If yes, specify: Date: _____ Time: _____
Supervisor's signature: _____ Date: _____
Member's signature: _____Date: _____
ICO's signature: _____ Date: _____