

**MONTANA MENTAL HEALTH NURSING CARE CENTER
EXPOSURE CONTROL PLAN
EXPOSURE INCIDENT REPORT FORM
*****CONFIDENTIAL*******

WRITTEN PERMISSION FROM THE EMPLOYEE REQUIRED FOR ACCESS

Employee Name: _____

Employee Social Security Number: _____

Date and Time of Incident: _____

Description of Possible Exposure Incident: (Include nature of exposure, PPE used, work practices in effect at the time, post exposure actions taken, the initials and medical record number of the source person or information available to identify the source of the blood or material involved).

Did an exposure occur? Yes/No

Referral made to Medical Evaluator? Yes/No

If yes, referred to: _____

Date: _____

If no, explain:

Completed by:

Name: (Please Print)

Signature & Title:

Date: