

**MONTANA MENTAL HEALTH NURSING CARE CENTER  
EXPOSURE CONTROL PLAN FORM  
POST EXPOSURE EVALUATOR WRITTEN OPINION**

\*\*\*\*\*CONFIDENTIAL\*\*\*\*\*

**WRITTEN PERMISSION FROM THE EMPLOYEE REQUIRED FOR ACCESS**

Employee Name/Title: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_

This employee has been referred to you because of an occupational exposure to blood or other potentially infectious materials. The details of the exposure incident are included in the Exposure Incident Report, which is attached.

The following forms are attached:

- Employee Medical Record Form (Policy 1516, Attachment #1)
- Exposure Incident Report Form (Policy 1512, Attachment #2)
- Post Exposure Medical Evaluation Form (Policy 1512, Attachment #4)

1. Hepatitis B Vaccine indicated? Yes/No

Vaccination dates: \_\_\_\_\_

2. Employee has been informed of my evaluation, exposure related conditions resulting from blood or other potentially infectious materials that require further evaluation or treatment.

\_\_\_\_\_  
Medical Evaluator Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date