MONTANA MENTAL HEALTH NURSING CARE CENTER
EXPOSURE CONTROL PLAN
POST EXPOSURE MEDICAL EVALUATION FORM

********CONFIDENTAL********

_____ _____
Employee Name (Please print) Date:

_____ _____
Medical Evaluator Name (Please print) Date:

Test(s) completed: _____
_____
_____
_____

Treatment given: _____
_____
_____
_____

Recommendations: _____
_____
_____
_____

_____ _____
Medical Evaluator Signature: Date:

_____ _____
Employee Signature: Date: