

**MONTANA MENTAL HEALTH NURSING CARE CENTER
EXPOSURE CONTROL PLAN
EMPLOYEE MEDICAL RECORD FORM
*****CONFIDENTIAL*******

WRITTEN PERMISSION FROM THE EMPLOYEE IS REQUIRED FOR ACCESS

Employee Name & Title: _____

Employee Social Security Number: _____

Date Hired: _____

Vaccination Status: _____

Vaccination Dates: _____

Hepatitis B Series Declination Form signed: Yes/No

HBV antibody test results: Positive / Negative / Not Done

Exposure Incident:

Date and Time of Incident: _____

Exposure Incident Report Form completed? Yes/No

Post Exposure Medical Evaluation Form completed? Yes/No

If no explain:

Post Exposure Evaluator Written Opinion Form completed? Yes/No

If no explain: _____

****This form must be kept for 30 years from the last date of employment. ****