BLOOD/BODY FLUID REPORT FORM

State Employee Injury Compensation Trust Fund
SEICTF

PART I

1. Employee's Name_____ 2. Agency_____
   Last First MI
3. Date of Incident_____ 4. Time of Incident_____ ( ) A.M. ( ) P.M.
5. Employee previously vaccinated against Hepatitis B (HBV): _____No _____Yes Date: _____
6. Check the route of exposure:

_____Needle stick, contaminated _____Scratch, skin broken _____Bite, skin broken _____Blood, on non-intact skin

_____Needle stick, non-contaminated _____Scratch, skin not broken _____Bite, skin not broken _____Blood, on intact skin

_____Splashing/spraying of blood or other potentially infectious material**

_____Other, please describe: _____

7. Source of exposure known: _____Yes _____No

Source tested: _____Yes _____No _____
Date

_____ _____
Supervisor's Signature Date

PART II

Due to contact with blood, body fluid or other potentially infectious material, I understand that I may have been exposed to a bloodborne pathogen. In order to determine if this has happened, it may be necessary to test my blood for HIV (virus which cause AIDS), HBV (virus which causes Hepatitis B) and/or HCV (virus which cause Hepatitis C). I authorize the health care facility performing the testing to release the test results to SEICTF and the follow-up physician.

I understand the results of these tests will be kept confidential and related costs will be paid by SEICTF. I further understand that SEICTF will have no responsibility to provide coverage to any state employee who refuses initial treatment, baseline blood testing, and/or release of test results for HIV, HBV and HCV.

Important: If HIV PEP medications are prescribed, you will be given the first dose in the emergency department and enough medication to last for up to 72 hrs. The network gatekeeper physician, whom you will report to for all follow-up care, will write prescriptions for the rest of the medicines. **It is your responsibility to take the prescriptions to your local pharmacy immediately and to instruct the pharmacy to contact the SEICTF, Pharmacy RN at 800-388-3406 to authorize your prescriptions.**

Sign one of the following:

A.) I understand the above, have been given the opportunity to ask questions and agree to treatment.

_____	_____	_____
Print Employee Name	Employee's Signature	Date
_____	_____	_____
Print Supervisor's Name	Supervisor's Signature	Date

B.) I understand the above, have been given opportunity to ask questions and REFUSE medical treatment, understanding that I am forfeiting my SEICTF benefits for this potential exposure.

_____	_____	_____
Print Employee Name	Employee's Signature	Date
_____	_____	_____
Print Supervisor's Name	Supervisor's Signature	Date