

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS

(THIS IS NOT A CLAIM FORM)

Name

Last _____ First _____ M.I. _____ Birth Date _____

1. _____ Phone No. _____

2. Address _____ City _____ State _____ Zip _____

3. Employer's or Firm's Full Name _____

4. Employer's or Firm's Address _____

5. Date of Exposure _____ Time of Exposure _____ A.M. _____ P.M.

6. Address or Location of Exposure _____

7. Job title _____

8. State fully how exposure occurred (be specific) _____

9. List all persons present at the exposure whom you can identify. _____

10. What bodily fluid were you exposed to?

Blood _____ Vaginal fluid _____ Any other fluid(s) containing blood (Describe) _____

Semen _____ Surgical fluid(s) _____ _____

11. Who did the bodily fluid come from: _____

(Explain) _____

12. Are you aware of break/rupture in the skin or mucous membrane at body location of exposure to bodily fluid and, if so, please describe.

13. Did exposure to bodily fluid take place through (a) skin _____ or (b) mucous membrane? _____

14. What specific part(s) of your body was exposed to bodily fluid? _____

15. **NOTE: THIS REPORT MUST BE FILED WITH YOUR EMPLOYER NO LATER THAN TEN (10) CALENDAR DAYS YOUR WORK EXPOSURE TO BODILY FLUIDS.**

OTHER REQUIRED STEPS:

- A. YOU MUST HAVE BLOOD DRAWN NO LATER THAN TEN (10) CALENDAR DAYS AFTER EXPOSURE.
- B. YOU MUST HAVE BLOOD TESTED FOR HIV OR HEPATITIS C BY ANTIBODY TESTING NO LATER THAN THIRTY (30) CALENDAR DAYS AFTER EXPOSURE AND TEST RESULTS MUST BE NEGATIVE.
- C. YOU MUST BE TESTED OR DIAGNOSED AS HIV POSITIVE NO LATER THAN EIGHTEEN (18) MONTHS AFTER THE EXPOSURE, OR TESTED AND DIAGNOSED AS POSITIVE FOR THE PRESENCE OF HEPATITIS C WITHIN SEVEN (7) MONTHS AFTER EXPOSURE.
- D. YOU MUST FILE A WORKERS' COMPENSTATION CLAIM WITH THE INDUSTRIAL COMMISSION OF ARIZONA NO LATER THAN ONE YEAR FROM THE DATE OF DIAGNOSIS OR POSTIVE BLOOD TEST IF YOU WISH TO RECEIVE BENEFITS UNDER THE WORKERS' COMPENSATION SYSTEM.

I HAVE FILED THIS FORM WITH MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE: _____ DATE _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA
FOR CARRIER USE

EMPLOYER: KEEP ORGINIAL (NOTIFY CARRIER)

EMPLOYEE: KEEP COPY