

**SAN JUAN ISLAND EMERGENCY MEDICAL SERVICES
EMPLOYEE INJURY/EXPOSURE REPORT**

Revised 02/2006

Employee Name _____ DOB _____

Title/Position _____

Date of Injury/Exposure _____ Time of occurrence _____

Where at workplace did this occur? _____

Where on your body did you sustain injury? _____

If an exposure occurred, is the source patient known? NO/YES

Source Patient Name _____

Describe what happened, how and why.

Evaluated by Physician NO/YES if not, why? _____

Physician Name _____ Date seen _____

Physician's Instructions:

Employee to be monitored for HBV and HIV? NO/YES If not, why?

Employee received counseling about the nature of their injury? NO/YES If not explain why:

Describe corrective action taken to prevent recurrence of this injury/exposure:

Form completed by _____ Title _____ Date _____

Reviewed by Administrator _____ Date _____

Reviewed by Medical Director _____ Date _____