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Notification of Blood or Body Fluid Exposure - Page 1 of 3

Emergency Medical Services Provider

Indiana State Department of Health

State Form 51467 (R / 11-11)

This form is to be completed by the exposed Emergency Medical Services Provider in compliance with IC 16-41-10-2.

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill-in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✱
4. Print capital letters only and numbers completely inside boxes: A 2 C 3
5. Please complete all items on form.
6. **Date format:** MM/DD/YY or MM/DD/YYYY
7. **Time format:** HHMM - 24 hour clock

SECTION 1: Information Regarding Emergency Medical Services Provider Exposed to Blood or Body Fluid

Last Name

First Name **MI** **Telephone Number** - -

Number & Street Address

City **State** **Zip Code** -

County **Date of Birth** / /

Sex: ○ Male ○ Female

E-mail Address

Race (fill in the circle(s) that apply):

○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White

Ethnicity: ○ Hispanic or Latino ○ Non-Hispanic

Employer

Address of Employer

City **State** **Zip Code** -

Telephone Number - - **Fax Number** - -

E-mail Address

SECTION 2: Exposure Information

Run Number (if applicable): **Date** / / **Time**

Location (fill in the circle that applies):

○ Incident Site ○ Ambulance ○ Emergency Department ○ Other

If Other, specify:

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SECTION 2: Exposure Information (Continued)

Person(s) whose blood or body fluid you were exposed to:

Name **Date of birth** / / ○ Unknown

Name **Date of birth** / / ○ Unknown

(add additional names on a separate sheet if necessary)

Fill in the circle(s) to indicate which fluid you were exposed to:

○ Blood ○ Saliva ○ Semen ○ Vaginal secretions ○ Unable to identify body fluid ○ Other

If Other, specify

Fill in the circle(s) that describe how the exposure occurred:

○ Skin broken with a contaminated needle or object

○ Eye, mouth, or other mucous membrane exposure

○ Non-intact skin exposure

○ Other, specify:

Comments and other pertinent information

SECTION 3: Submitting Completed Form

The Emergency Medical Services Provider must submit a copy of this report to **each** of the following:

1. Employer's Medical Director (**must be notified within 24 hours of exposure**)

Name of Medical Director

Address

City **State** **Zip Code** -

Date: / / **Time**

SECTION 3: Submitting Completed Form (Continued)

2. Emergency Department's Medical Director:

Name of Medical Director

Name of Medical Facility

Address

City **State** **Zip Code** -

Date / / **Time**

3. Indiana State Department of Health
2 North Meridian Street, 5K
Indianapolis, IN 46204
FAX: 317-234-2812

Date / /

SECTION 4: Exposure Follow-up Notification

Fill in the circle next to the physician you want to receive the results of the testing done in accordance with 16-41-10. The physician of your choice must inform you of the results of testing within 48 hours of receiving the results.

○ Exposed Emergency Medical Services Provider's Physician

Name

Address

City **State** **Zip Code** -

Telephone Number - - **Fax Number** - -

○ Employer's Medical Director (named on Page 2).

SECTION 5: Signature and Date

Signature of exposed Emergency Medical Services Provider

Date / /