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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

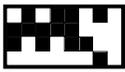
\_\_\_\_\_  
Run Number (if applicable):

\_\_\_\_\_  
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	<input type="radio"/> Unknown	

	/	/	
Name	Date of birth	<input type="radio"/> 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:

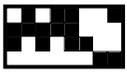
1. Employer's Medical Director (must be notified within 24 hours of exposure)

Name of Medical Director

Address

	-	
City	State	Zip Code

/	/			
Date:		Time		



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### 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