## POST-EXPOSURE EVALUATION AND FOLLOW-UP FORM CSUCI Bloodborne Pathogen Exposure Program

- 1. As part of my employment with California State University Channel Islands, I may have been exposed to blood or other potentially infectious materials on the following date: \_\_\_\_\_
- 2. The means of exposure was: \_\_\_\_\_
- 3. Name and address of the source individual:
- 4. A Supervisor's Injury or Illness Report was filed with Human Resources on: \_\_\_\_\_

I further undestand that as a result of this exposure I may require evaluation or treatment due to the potential risk of acquiring Hepatitis B virus, HIV or other bloodborne infection. I was offered and encouraged to have a confidential medical evaluation and follow up, and have been given the opportunity to be vaccinated with the Hepatitis B vaccine and/or Hepatitis B Immune Globulin at no charge to myself.

## Please check the following that apply:

- 🔲 I accept Hepatitis B Immune Globulin treatment.
- □ I accept the Hepatitis B vaccination series.
- ☐ I decline the Hepatitis B vaccination series.
- ☐ I decline Hepatitis B Immune Globulin treatment.
- □ I consent to baseline blood collection and HBV serological testing.
- I do not consent to baseline blood collection.
- I consent to baseline blood collection but do not consent to any testing at this time. I understand that the blood sample shall be perserved for at least 90 days. If, within 90 days of the exposure incident, I
- elect to have the samples tested for either HBV and/or HIV, such testing shall be done as soon as feasible.

EMPLOYEE SIGNATURE	DATE
NAME (PLEASE PRINT)	PROGRAM OR AREA OF WORK
PHYSICIAN SIGNATURE	DATE

- Exposure Incident Report Form has been completed (copies forwarded to EHSRM and Human Resources).
- Source individual's blood has been tested (provided consent was obtained).
- Exposed employee has been notified of the test results.