

CABELL COUNTY EMERGENCY MEDICAL SERVICES
INFECTION EXPOSURE FORM

Exposed Member's Name _____

Rank _____ S.S.# _____ Shift _____

CR# _____ Name of Patient _____

Sex _____ Age _____ Address _____

Suspected or Confirmed Disease _____

Transported to _____

Transported by _____

Date of Exposure _____ Time of Exposure _____

Type of Incident (auto accident, trauma) _____

What were you exposed to:

Blood _____ Tears _____ Feces _____ Urine _____ Saliva _____

Vomit _____ Sputum _____ Sweat _____ Other _____

What part(s) of your body became exposed? Be specific _____

Did you have any open cuts, sores, or rashes that became exposed?

Be specific _____

How did the exposure occur? Be specific _____

Did you seek medical attention? Yes _____ No _____

Where _____ Date _____

Contact Infection Control Officer Date _____ Time _____

Supervisor's Signature _____ Date _____

Member's Signature _____ Date _____