

RRDSSAB Exposure Report

PERSONAL INJURY NEEDLE STICK BLOOD & BODY FLUID

PERSONAL INJURY/NEEDLE STICK/BLOOD & BODY FLUID EXPOSURE REPORT

If you are injured, receive a needle stick injury or are exposed to blood or body fluids from a patient that you know or you suspect to have a communicable disease, you shall complete this report and submit it to the EMS Supervisor A.S.A.P. This report is for personal injuries/exposures only. It is not to be used for vehicle accidents or any other situations. This completed report will be used to complete the required WSIB forms, all of which are required to be completed within 48 hours. As such, please ensure that all information is accurate and complete.

NAME: _____

CITY EMPLOYEE #: _____

ADDRESS: _____

POSTAL CODE: _____ PHONE #: _____

TOTAL YEARS EMS EXPERIENCE: _____

DATE AND TIME OF INCIDENT: _____

SHIFT WORKING: _____

DATE AND TIME REPORTED: _____

REPORTED TO: _____

ADDRESS/EXACT LOCATION OF INCIDENT:

TREATMENT: FIRST AID/WASH UP ONLY

MEDICAL TREATMENT

DR's NAME: _____

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TYPE & AMOUNT OF BODY FLUID: _____

BLOOD VISIBLE IN FLUID: YES NO

IF NEEDLE STICK INJURY:

NEEDLE TYPE _____

CLEAN NEEDLE: YES NO

RECAPPING INCIDENT: YES NO

IDENTIFY SAFETY EQUIPMENT BEING WORN/USED AT TIME OF INCIDENT:

DESCRIBE WEATHER CONDITIONS IF APPLICABLE:

WAS ANOTHER PERSON INVOLVED IN THE INCIDENT? YES NO

IF YES, WHAT WAS THEIR INVOLVEMENT:

NAME:

PARTNER TO COMPLETE STATEMENT ON PAGE 4, IF APPLICABLE

WITNESS OTHER THAN PARTNER: YES NO
(if yes, ensure completion of statement, see page 5)

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EMPLOYEE STATEMENT

Explain what happened to cause the incident and describe your activities at the time of the incident (*use sketch if necessary*):

EMPLOYEE'S SIGNATURE: _____

DATE: _____

TIME: _____

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PARTNER STATEMENT

Explain what happened to cause the incident and describe your activities at the time of the incident (*use sketch if necessary*):

PARTNER'S SIGNATURE: _____

DATE: _____

TIME: _____

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WITNESS STATEMENT

Explain where you were and what you saw in relation to the incident (*use sketch if necessary*)

WITNESS NAME: _____

ADDRESS: _____

PHONE #: _____

SIGNATURE: _____

DATE: _____

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HEALTH & SAFETY - INCIDENT INVESTIGATION

MANAGEMENT INVESTIGATION AND RECOMMENDATIONS:

SIGNATURE: _____ DATE: _____

MANAGER'S COMMENTS:

SIGNATURE: _____ DATE: _____

JOHSC COMMENTS/RECOMMENDATIONS:

SIGNATURE: _____ DATE: _____