**University of South Alabama**
Pat Capps Covey College of Allied Health Professions
**Evaluation of Circumstances Surrounding an Exposure Incident Form**

| Name: (student, employee) | Department: |
|---|---|
| Incident location: (facility name, address) | Incident date: |
| Procedure being performed: | |
| Description of device being used (including type/ brand): | |
| Work practices followed: (see ECP p.9.) | |
| PPE or clothing in use: (gloves, eye shields, etc.) | |
| Engineering controls in use: (see ECP p.9.) | |
| Suggested changes to prevent reoccurrence? (list procedural changes that will decrease risk) | |

PEP verification:
(explain any No responses on reverse of form)

| | Yes | No |
|---|---|---|
| 1. Was an exposure risk determination performed? | ☐ | ☐ |
| 2. Were baseline labs* drawn on exposed individual? | ☐ | ☐ |
| 3. Was PEP offered by the training facility? | ☐ | ☐ |

*

HBV vaccination status:

Vaccine series completed? ☐ (yes) ☐ (no) *or* Titer confirmed ☐ (yes) ☐ (no)

BBP/TB training confirmation:
(date completed)

BBP training date ________________________ TB training date ___________________

**Person completing form:**

Printed name: ____________________________________ Title:__________________________

Signature: _______________________________________ Date: ____________

**Additional Comments:**

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

------------------------------------------------------------------------------------------------------------------------------------

**Form Routing:**

Student/Employee: _______________________________ Date Submitted: _______

Training Preceptor/Supervisor: ______________________ Date Received: _______ Sent: ___________

Department Chairperson: ___________________________Date Received: _______ Sent: ___________

Biosafety Officer: ________________________________ Date Received: _______ Sent: ___________

Dean's Office: ___________________________________ Date Received: _______ Sent: ___________

INSTRUCTIONS: Please return form to Department for filing in permanent student/employee record