Form 350

Emergency Medical Service Provider Exposure Report Form

PLEASE PRINT OR TYPE

Complete this form to document exposure to blood and/or other body fluids. Most unprotected exposures do not result in an infection, however, some people can be exposed to a disease and not have any symptoms of illness. It is important that you document any significant exposure incident.

Significant Exposure – EMS Provider Information

Exposed Provider, use your last initial, first initial, last 4 digits of Social Security number for ID # ex. (ab1234) ID # _____

Employee Name _____ DOB _____/_____/_____ Sex _____

(Last) (First) (M) M or F

Home Phone _____ Work Phone _____ Employer/Agency _____

Contact Person at Employment / Agency _____ Contact Phone _____

Date _____ Incident # _____

Mechanism of Exposure (check all that apply)

	Body Fluid Exposure		Other Body Fluid w/Blood		How Were You Exposed?
	Blood		Saliva		Splash in Eye
	Birth Fluids		Urine		Splash in Mouth or Nose
	Pericardial Fluids		Feces		Bite
	Pleural Fluid		Pus		Puncture w/Hollow-bore Needle
	Synovial Fluid		Sputum		Puncture Cut w/Other Sharp Implement
	Cerebrospinal Fluid		Other		Open Wound
	Semen				Rash / Dermatitis
	Vaginal Secretions				Abrasion

What protective equipment were you using at the time of exposure? (check all that apply)

	Bag-Valve-Mask		One Way Resuscitation Mouthpiece		Paper Gown
	Gloves		N-95 Mask		Other
	Eye Protection		Surgical Mask (Less than N-95 rating		

Source of Significant Exposure – Source Patient Information

Source Patient Name _____ Phone Number _____

Source Patient Address _____ (Street Address) DOB _____/_____/_____

_____ (City, State, Zip) Sex: M _____F_____

☐ I hereby give my permission to the facility named below to draw and test my blood for any or all of the following: ☐ HIV Antibody, ☐ HBV/Surface Antigen and, ☐ HCV Antibody. I understand that the results of this testing are private information and will be confidential.

☐ I refuse to have my blood drawn and tested. I understand that a court order may be pursued to require me to have blood testing done.

Source Patient (or responsible) Signature _____ Date _____/_____/_____

Receiving Facility/Testing Laboratory

Receiving Facility _____ Date Specimen(s) were obtained _____/_____/_____

Testing Laboratory _____ Date Specimen(s) were submitted _____/____/_____

Did patient expire? ☐ Yes ☐ No Was the patient under the jurisdiction of the State Department of Corrections (Prisoner or Parolee)? ☐ Yes ☐ No

Name of Person submitting report _____

Title _____ Phone Number _____ Date Report was submitted _____/_____/_____

If onsite post exposure counseling is not available contact any of the following. http://www.ucsf.edu/hivcntr/Hotlines/PEPline.html 24/7
Or call (800) 537-1046. (801) 538-6096 or (800) FON-AIDS 8-5 M-F (hospital clinicians may receive 24/7 help with PEP counseling by calling 1-888-448-4911)
The Laboratory must report the test results of the source patient testing to the EMS Agency/Employer Contact person listed above.

* The EMS Agency/Employer must submit the Employer's First Report of Injury/Illness (Form 122) when this form is completed by an EMS Provider.

Official Form 350 **Revised 8/2012**

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