Bloodborne Pathogens
Post-Exposure Incident Packet

An employee who is exposed to another individual's blood or Other Potentially Infected Materials (OPIM) is required to complete the following steps:

1. Seek *immediate first aid* from a Security Officer or Health Services, if necessary. Call 911 if it is a life-threatening situation.

2. Complete the First Report of Injury (FROI) Form with your supervisor. The FROI needs to be returned to the Office of People & Culture as soon as possible.

3. Contact the Office of Safety & Security to inform them of the incident. They will provide you with this Post-Exposure Incident (PEI) packet and can help you get started. Health Services can also assist if the incident occurs during normal business hours. Directions on the next page indicate where PEI forms should go.

4. Make an appointment with a healthcare provider for a post-exposure medical evaluation, as necessary (the contacts below can help direct you if needed).

For assistance with this packet or process, please seek guidance from the departments below:

Office of Safety & Security	651-638-6000	Safety-security@bethel.edu
Office of People & Culture	651-638-6119	People-culture@bethel.edu
Health Services	651-638-6215	Health-services@bethel.edu
Health & Safety Consultant (IEA, Inc.)	763-315-7900	Facilities-management@bethel.edu

Form Routing Information

FORM	ROUTING	
	Take with you to the medical provider (as indicated)	*Send to the Benefits Administrator in the Office of People & Culture*
BBP Exposure Self-Assessment and Immediate Response Process	✔	
Post-Exposure Instructions and Response Actions	✔	
Exposed Employee Declination of Medical Evaluation		✓ Original
Transmittal Letter to Healthcare Professional	✓ Original	✓ Copy
Exposed Individual – Consent/Declination for Blood Testing	✓ Original	✓ Copy
Source Individual – Consent/Declination for Blood Testing	✓ Original	✓ Copy

- All forms will ultimately be submitted to the Benefits Administrator in the Office of People & Culture.

- Exposed Individual: Take the forms indicated above to your medical provider with a copy of the OSHA regulation - 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens which is attached to the end of the packet

- Medical Provider: Send copies of completed forms to the Benefits Administrator in the Office of People & Culture.

- Complete the form, "Exposed Employee Declination of Medical Evaluation" **only** if the employee does not want medical attention. No other forms would need to be completed in this case. Forward the completed declination to the Benefits Administrator for recordkeeping in the Office of People & Culture.

BBP Exposure Self-Assessment & Response Process

Employee shall follow the steps listed below:

1. Seek immediate first aid from a Security Officer or Health Services, if necessary.
2. Answer the following questions to determine if the incident you've been involved in should be considered an "exposure" to bloodborne pathogens or other potentially infectious materials (OPIMs). **Any YES answer means an "exposure" has occurred.** Initial your answers. *Make sure to ask for clarification if you're not sure of any answer!*
3. **Questions: Did the contact with blood OR other potentially infectious materials (OPIMs) include any of the following:**

	YES	NO	Initials
Blood or OPIMs in your eyes, nose, or mouth			
Blood or OPIMs in contact with your broken skin (less than 24 hours old), including cuts or open skin rashes, or breaking of your skin in a bite?			
Penetration of your skin by a blood or OPIM contaminated sharp (needle, lancet, glass, teeth, etc.)?			

Description of Incident:

_____

_____

_____

_____

_____

_____

_____

4. **If you answered NO to ALL questions above, an exposure did not occur and medical attention for exposure to blood or OPIMs is not required.** Other medical attention may still be appropriate. You may stop here and give this form to your supervisor. Report other injuries or concerns involved in this event, if applicable. *Please ask for help or if you have questions about this determination.*
5. **If you answered YES to any of the above questions** go to the next page for additional instructions.

_____ _____

Employee Name Employee Signature

_____

Date

Post-Exposure Instructions and Response Actions

Bethel University has not identified a primary provider for post-exposure health care services.

Exposed employees may seek a medical evaluation through a provider of their choice, at no cost to the employee.

General Instructions:

1. If you choose not to seek a medical evaluation, complete the "Exposed Employee Declination of Medical Evaluation". Send the original to the Benefits Administrator in the Office of People & Culture to keep in your records, and no further action is required.

2. Complete the "Transmittal Letter to Healthcare Professional" form. Take this form, give it to the doctor or nurse and ask that they process the form.

3. Obtain medical care as soon as possible or within 24 hours. **Take this packet with you.**

   - The medical provider should complete a Written Medical Opinion and send it to the university. This should include whether the Hepatitis B vaccine was provided and whether the exposed individual was informed of the results of the evaluation, including any results that may require further evaluation or treatment.

4. Complete the "Exposed Individual – Consent/Declination for Blood Testing" form, and TAKE IT TO THE CLINIC.

5. "Source Individual – Consent/Declination for Blood Testing" form. The individual's supervisor will contact the source individual to discuss obtaining consent or declination for blood testing. The source individual can go to the medical provider of their choice and bring the signed consent form with them. *If a minor child is involved or you are unable to get the adult source individual to sign this form, involve the Office of People & Culture.*

6. Provide copies of all event-related documents to the Benefits Administrator in the Office of People & Culture. Communicate with your supervisor regarding job restrictions, return-to-work date, or other appropriate information.

Exposed Employee Declination of Medical Evaluation

The exposed employee must complete this form if he or she chooses not to receive medical care for a work-related exposure involving blood or OPIMs.

Employee Name	Job Title
Date of Exposure	Primary Work Building

I have been given the opportunity for a post-exposure follow-up examination, including testing of my blood for HBV, HCV and HIV.

I understand that I may obtain this examination through the medical provider of my choice.

Medical services will be provided at no cost to me for work-related incidents involving exposure to blood or other potentially infectious materials. I understand that I am eligible for this examination even if I have been previously vaccinated against HBV.

I have been offered the opportunity to have a sample of my blood drawn and preserved for 90 days in case I choose to have it analyzed within the 90 days.

Understanding the information written above, I decline any post-exposure medical evaluation, blood sampling, blood testing, or follow-up examination at this time.

Employee Signature	Date

Transmittal Letter to Healthcare Professional

Today's Date: _____ Date of Exposure Incident: _____

Exposed Employee: _____

Date of Birth: _____

The identified employee has been exposed to blood or other potentially infectious body fluids, and requires a medical evaluation, per OSHA Regulation 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens.

To assist in conducting the medical evaluation, we have attached the following information and forms:

□ Copy of the OSHA standard 29 CFR 1910.1030
□ Completed First Report of Injury form (from the Office of People & Culture)
□ Exposed Individual – Consent/Declination for Blood Testing (Results to be transmitted directly)
□ Source Individual – Consent/Declination for Blood Testing (Results to be transmitted directly)

We request that you complete a confidential medical evaluation for the employee, including all appropriate treatments, counseling, and evaluation of illnesses. Your written opinion must be provided to the Benefits Administrator listed below. This written opinion should include whether the Hepatitis B vaccine was provided and whether the exposed individual was informed of the results of the evaluation, including any results that may require further evaluation or treatment. All other medical information is maintained by your facility.

Please return the written opinion within 12 days for timely distribution to the employee to the contact listed below.

Please also send the invoice for the employee's post-exposure medical evaluation to the contact below.

ATTN: Benefits Administrator
Office of People & Culture
2 Pine Tree Drive
Arden Hills, MN 55112

Phone: 651-638-6119

Post Exposure
Exposed Individual – Consent/Declination for Blood Testing

(Review instructions prior to completing this form)

Employee Name: _____ Today's Date: _____

Date of Incident: _____

On the above date, an exposure incident, as defined by the Federal and Minnesota State Bloodborne Pathogen Regulations, occurred involving an employee performing his/her duties.

The regulation requires that a sample of blood be drawn as soon as possible from the source individual and the exposed employee to determine if infectious diseases are present.

We are requesting to have your blood drawn and tested for Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) in order to provide appropriate medical direction. You are not legally required to consent to having your blood drawn and tested. In the event that you decline to have your blood drawn and tested, however, we will not be able to determine whether you have been infected by HBV, HCV, or HIV or advise or counsel you on appropriate steps to take as a result of such an infection.

Please read the following and, if you consent, sign and date the form. Directions will be provided on the location for the test and the cost will be paid by Bethel University. You will be provided with the test results as soon as possible.

If you know you are infected with HBV, HCV or HIV and can provide medical records or documentation, no blood test is necessary.

1. I authorize and consent to testing of a sample of my blood for the following: *(check only one)*
   - □ Human Immunodeficiency Virus (HIV)
   - □ Hepatitis B Virus (HBV)
   - □ Hepatitis C Virus (HCV)
   - □ All of the above: the Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV)

2. I understand that a positive HIV test does not necessarily mean a person has AIDS; testing can assist healthcare personnel in medical management and infectious disease control of the virus.

3. I understand that I should rely on my medical provider for information regarding the nature and purpose of the HIV/HBV/HCV test and the meaning and significance of the result of the test.

4. I understand that HIV/HBV/HCV testing is not always 100% accurate and that results may be "false negative" (negative results when the virus is actually present) or "false positive" (positive results when the virus is not present). If a positive result is obtained, additional tests will be done to attempt to confirm the test results.

(continued on next page)

Form, continued

5. I understand the results of the test will be confidential and will not be disclosed unless it is necessary for Bethel University to comply with the provisions of OSHA's Bloodborne Pathogen Regulation (29 CFR 1910.1030).

6. I understand I can personally make arrangements to have my blood drawn, as authorized, or that arrangements will be made for me, with the assistance of Bethel University personnel or other designated parties.

7. I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give this informed consent/declination.

□ I consent to have my blood drawn and tested at this time or drawn and stored for up to 90 days for possible future testing, upon my written consent.

□ I decline to have my blood drawn and tested at this time or drawn and stored for up to 90 days for possible future testing, upon my written consent.

_____ _____

Employee Signature Date

Return this form to the Benefits Administrator in the Office of People & Culture.

Post Exposure
Source Individual – Consent/Declination for Blood Testing

(Read form completely prior to completing)

Name of Source Individual: _____ Today's Date: _____

Date of Incident: _____

On the above date, an exposure incident, as defined by the Federal and Minnesota State Bloodborne Pathogen Regulations, occurred involving an employee performing his/her duties.

The regulation requires that a sample of blood be drawn as soon as possible from the source of the exposure and the exposed employee to determine if infectious diseases are present.

We are requesting to have your blood drawn and tested for hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV) in order to provide appropriate medical direction. If you are a minor, consent to have your blood drawn and tested must be given by your parent or guardian. You are not legally required to consent to having your blood drawn and tested. In the event that you decline to have your blood drawn and tested, however, we will not be able to determine whether you have been infected by HBV, HCV, or HIV or advise or counsel you on appropriate steps to take as a result of such infection.

Please read the following and, if you consent, sign and date the form. Directions will be provided on the location for the test, and the cost, if not covered, will be paid by Bethel University. You will be provided with the test results as soon as possible.

If you know you are infected with HBV, HCV, or HIV and can provide medical records or documentation, no blood test is necessary.

1. I authorize and consent to testing of a sample of my blood for the following: *(check only one)*
   - □ Human Immunodeficiency Virus (HIV)
   - □ Hepatitis B Virus (HBV)
   - □ Hepatitis C Virus (HCV)
   - □ All the above the Human Immunodeficiency Virus (HIV) and the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV)

2. I understand that a positive HIV test does not necessarily mean a person has AIDS; testing can assist healthcare personnel in medical management and infectious disease control of the virus.

3. I understand that I should rely on my medical provider for information regarding the nature and purpose of the HIV/HBV/HCV test and the meaning and significance of the result of the test.

4. I understand that HIV/HBV/HCV testing is not always 100% accurate and that results may be "false negative" (negative results when the virus is actually present) or "false positive" (positive results when the virus is not present). If a positive result is obtained, additional tests will be done to attempt to confirm the test results.

(continued on next page)

Form, continued

5. I understand the results of the test will be confidential and will not be disclosed unless it is necessary for Bethel University to comply with the provisions of OSHA's Bloodborne Pathogen Regulation (29 CFR 1910.1030). Disclosure will be made to the exposed employee and their healthcare professional.

6. I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give this informed consent/declination.

□ I consent to have my blood drawn and tested at this time or drawn and stored for up to 90 days for possible future testing, upon my written consent.

□ I decline to have my blood drawn and tested at this time or drawn and stored for up to 90 days for possible future testing, upon my written consent.

_____ _____

Employee Signature Date

Return this form to the Benefits Administrator in the Office of People & Culture.