

**CITY OF PHOENIX FIRE DEPARTMENT
INFECTIOUS/COMMUNICABLE DISEASE
EXPOSURE INCIDENT FORM**

_____ FAXED
_____ DATA ENTRY
_____ ECO COMPLETION

USE PEN - PRINT ONLY

Exposed employee: _____ Social Security Number: _____

Current Assignment - Company/Shift _____ Home Phone No: _____ Pager No: _____

Company/Shift when exposure occurred _____ Field Incident No. _____

Date of Exposure: ____ / ____ / ____ Map Page: _____ Time of Exposure: _____

Address/Location of Exposure: _____

Describe the circumstances surrounding the incident/exposure (be specific): _____

What disease was Suspected Confirmed? Confirmed by: _____

HIV Hepatitis TB Meningitis Other _____

What were you exposed to ? Blood Saliva Vomitus Semen Vaginal Fluid Urine Feces

Airborne Other (specify): _____

What part(s) of your body were exposed (be specific): _____

Did you have any open cuts, sores, rashes that were exposed (be specific): _____

List and describe all personal protective equipment you were wearing at the time of exposure:

Gloves Mask Gown Sleeves Eye Protection Face Shield

Other _____

List all engineering and work practices (i.e. handwashing, antiseptic used) that were in place at the time of the incident: _____

Could the incident/exposure have been avoided? If so, how? _____

Are there any changes recommended to avoid similar future incidents? _____

Did you receive medical treatment? YES NO Where? _____

SOURCE PATIENT INFORMATION: Name: _____ Age: _____
DOB: _____ Social Security #: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone No.: _____ Transported by: _____
Hospital transported to: _____ Time Transported: _____ Hospital PID#: _____

Type of Incident: <input type="checkbox"/> Code <input type="checkbox"/> Trauma <input type="checkbox"/> D/B <input type="checkbox"/> 962 <input type="checkbox"/> Medical D901H <input type="checkbox"/> Other _____
Did you contact dispatch? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____ Date: _____ Who: _____
Police on scene? <input type="checkbox"/> Yes <input type="checkbox"/> No Officer's Name: _____ Other Units on Scene: _____
Were you contacted by an Exposure Control Officer? <input type="checkbox"/> Yes <input type="checkbox"/> No

Supervisor's Signature _____ Date: _____

Supervisor's printed name: _____

Employee's Signature _____ Date: _____