

Washington County EMS Infectious Disease Exposure Report (rev12/06)

Today's Date: _____ Your Name: _____

Last First

Provider ID#: _____ Primary Affiliation: _____

Your Address: _____
Street City State Zip

Mailing Address if different: _____

SSN: _____ Your pay status at time of exposure: _____

Date of Exposure: _____ Incident #: _____ Unit #: _____

Location of Call: _____ Estimated time of exposure: _____

Patient's Name: _____ Route of exposure: _____

Patient's Address: _____
Street City State Zip

Hosp. Transported to: _____ Name of ED Supervisor notified: _____

Were you seen/treated in ER? (*circle one*) Yes No

If not, will you be treated later and where? _____

Were you seen/treated at [Health@Work](#)? (*circle one*) Yes No

First Report of injury completed? (*circle one*) Yes No

Briefly describe what happened: _____

What do you feel could have been done to avoid this exposure? _____
