PLAN REVIEW	
Reviewer	***Date***
Eileen Carlson	9/21/2015
Brian Parrie	2/21/2017
Shane Carlson	2/16/2018
Shane Carlson	9/19/2019
Shane Carlson	7/22/2020

Contact: Jennifer Seeley
(507) 232-3411 ext. 3108

BLOODBORNE PATHOGENS

Jennifer Seeley is the contact person for this program. Sue maintains a copy of the of the program plan and training outlines at her office.

TRAINING OUTLINES

AWAIR

*Safety Committee (Members, chain of command)
*OSHA 300 Log (Federal Govt. requirement)
*First Report of Injury (Fill out of injury if beyond first aid)
*Concerns (Safety)

BLOODBORNE PATHOGENS

*Introduction
*At-Risk Employees (By job description)
*Exposure Control Plan
*Cleanup Procedures (Universal precautions)
*Disposal Procedures (Policy of school, red bag if saturated with blood – Biohazard)
*HBV Vaccination Policy (At risk- Paid by school district) District may offer to all
*Engineering Controls
*Post Exposure Procedures

HAZARD COMMUNICATION/RTK

*Introduction
*OSHA (Occupational Safety and Health Admin.)
*Routes of Entry (Dermal, inhalation, ingestion,etc.)
*PPE (Personal Protective Equipment)-Gloves, etc.
*Labeling (All containers should be labeled)

*MSDS's (Have one for each chemical, also have an inventory of chemicals)
*Disposal (Properly store and dispose of)

I.A.Q.

*IAQ Committee (Know who is on committee)
*Record keeping (Forms and procedures for addressing concerns)
*Management Plan
*IAQ issues/concerns (Know who the contact is)

Sharps Injury Log

Date: _____
Location: _____
Engineering controls in use at the time of the incident: _____
_____
Work practices followed: _____
_____
Description and brand name of the device in use: _____
_____
Protective equipment or clothing that was used at the time of the exposure incident:
__
_____
Procedure being performed when the incident occurred: _____
_____

Employee training: _____

The injured employee's opinion about whether any other engineering, administrative, or work practice controls could have prevented the injury and the basis for that opinion. _____
_____
_____
_____
_____

Form B
BLOOD EXPOSSURE INCIDENT REPORT

Complete items 1-9. Items 10-14 should be filled out by the employer (school district representative).

Employee's Full Name: _____

Employee's Social Security Number: _____

Person Completing Form: _____

Date of Incident: _____
Time of Incident: _____
Date and Time Incident Report: _____
Incident Reported by: _____

The employee named above was involved in an exposure incident consisting of blood or other potentially infectious material (OPIM) involving the employee's mouth, eyes, or other mucous membranes, open cuts, non-intact skin, or piercing of mucous membranes or skin.

The following exposure incident information was obtained to help assist the Healthcare Professional in completing the medical evaluation of the employee.

1. Exposure route to blood or OPIM. Check the following:
   A. _____ Eyes _____ Mouth _____ Nose _____ Other mucous membrane (list): _____
   B. _____ Needlestick _____ Puncture _____ Bite _____ Scratch
   C. _____ Non-intact skin
   D. _____ Other (list):

   Comments: _____

2. Type of body fluid or material
   _____ Blood
   _____ Other potentially infectious material (List): _____

Comments: _____

3. Estimated amount of body fluid or description of amount:
_____

4. Severity of Exposure:
A. _____ Mucous Membranes _____ Area covered
_____ Exposure length (time)

Comments: _____

B. _____ Percutaneous (skin piercing) _____ Injury depth
_____ Yes _____ No, was source fluid present at injury site:

Comments: _____

C. _____ Non-intact skin
_____ Skin condition: _____ Fresh cuts (<24 hrs) _____ chapped
_____ Dermatitis _____ Other
Comments: _____

5. Job duties being performed during exposure: _____

6. Did employee wash hands and/or flush the mucous membrane as soon as possible:
_____ Yes _____ No

Comments: _____

7. Was employee using Person Protective Equipment (PPE)?
_____ Yes _____ No If yes, what types: _____

Comments: _____

8. Was the Personal Protective Equipment (PPE) adversely affected:
(examples: gloves torn or pierced) _____ Yes _____ No
If yes, list: _____

Comments: ____

9. Was clothing contaminated: _____ Yes _____ No
If yes, were procedures for disposal/laundering of contaminated materials adhered to:
_____ Yes _____ No

Comments: ____

If employee does not want his/her blood tested or a medical follow-up, then Form E should be completed by signing the Declination section for blood testing, and also Form G "Post-Exposure Declination of Medical Evaluation".

_ _

TO BE COMPLETED BY EMPLOYER-

10. Has employee been referred to a healthcare professional for medical evaluation and follow-up? _____ Yes _____ No

Name and location of professional/clinic (unless employee has made arrangements with his/her own physician. If this is the case, obtain the name and address of the employee's physician):
____

____

11. Was the source's blood tested? _____ Yes _____ No
If yes, are results being directly forwarded to Healthcare Professional?
_____ Yes _____ No

If no, record the date of consent for testing source was declined:
____
If no, was source known? _____ Yes _____ NO

Source is known to be infected with:
_____ HIV _____ HBV _____ Not applicable

12. Employee's consent for blood collection (See Form E):

_____ Employee consented to baseline blood collection

Employee consented to the serologic testing for HBV:
_____ Yes _____ No

Employee consented to serologic testing for HIV:
_____ Yes
_____ No, sample is preserved for 90 days. Employee may elect to have test
conducted within 90 days.
Date: _____

13. All required documents were provided to professional/clinic on the following date (See Form C):

_____

14. Has employee had Hepatitis B vaccination? _____ Yes _____ No

If the employee has indicated that no medical follow-up is to be done, please make sure that Form G is filled out and signed.

Signature _____ Date _____

Hepatitis B Vaccination Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself.

However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood and/or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I may receive the vaccination series at no charge to me.

Please Print:

Name _____ Date of Birth _____

Social Security or Visa # _____ Employee #_____

Department and Lab room # _____

Principal Investigator _____

Signature _____ Date _____

Contact your BBP Contact Person if you have questions filling out this form