Date/Yr/Time of Incident: _______________________________________________________

Individual (ATS) Involved/Exposed: ________________________________

Employee Involved/Exposed: ________________________________

Brief Summary of Incident/Exposure: ______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Route of Contamination (e.g. pinprick, etc.):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Were proper precautions taken: ________________
If not, explain why:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Was incident due to equipment or procedure error? ________________
If yes, explain:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Plan: All Athletic Training Students who are involved/ exposed must receive follow-up care and evaluation in the Engle Health Center.

Date/Yr/Time the ATS was referred to Engle Center: ____________________________________________

If individual (ATS) is involved/exposed, did they receive care/referral to the Engle Health Center? _____

Blood work drawn after incident:
Employee: _____________________________________________________________
Individual (ATS): _______________________________________________________

Signature of Involved/Exposed Individual: _________________________________
Date: _____________________________

Signature of Supervisor: _________________________________
Date: _____________________________

Signature of Engle Health Center Nurse/ Nurse Practitioner: _________________________________
Date: _____________________________

Date/Yr E.I.R. filed in the record: ____________________________________

10/1/2018