WALLA WALLA UNIVERSITY
BLOODBORNE PATHOGENS EXPOSURE PACKET

INSTRUCTIONS AND DOCUMENTS FOR SUPERVISORS AND CAMPUS SECURITY
IN THE EVENT OF AN INCIDENT

1. Determine first if an exposure to blood or other potentially infectious material has actually occurred. If you are unsure, consult with Risk & Safety Management. If you are still unsure, handle the incident as an exposure until a determination is made by medical evaluation.

2. Notify Campus Security that an exposure incident has occurred. Off-Campus Site variances:
   - Billings--notify the Administrative Assistant
   - Missoula--notify the Administrative Assistant
   - Portland--notify the Officer Manager or the Dean of School of Nursing
   - Rosario--notify the Manager or Academic Director

3. Obtain the Bloodborne Pathogens Exposure Packet from Campus Security. Off-Campus Site variances:
   - Billings--obtain from the Administrative Assistant
   - Missoula--obtain from the Administrative Assistant
   - Portland--obtain from the Office Manager or Dean of School of Nursing
   - Rosario--obtain from the Manager or Academic Office

4. Supervisors must complete:
   - the Work-Related Accident/Incident Report and return it to Human Resources within 24 hours.
   - the Post-Exposure Form with signatures, send a copy to Human Resources, and include the original along with the Medical File Report Form in the packet sent with the employee to the emergency department or other licensed health care provider of their choice. (for **best results, testing must be done within 20 minutes and prophylactic medicine administered within 2 hours of the exposure**). Healthcare providers should complete the Medical File Report Form and return it to Human Resources within 15 days of the evaluation.
   - the Accident/Incident Investigation Report and return it to Human Resources within 72 hours after the incident. The exposed employee’s supervisor, or their designated representative, will participate in the investigation with the employee to determine:
     - the procedure/task being performed when the incident occurred
     - the location, date, and time of the incident
     - the engineering controls available and in use
     - work practices
     - the equipment in use, including type and brand if applicable
     - the work uniform and personal protective equipment available and in use
     - the employee’s training

5. If a source individual cannot be identified, is unavailable, or will not consent to testing, the exposed employee will be notified. If the source individual is known and is available, inquiries should be made to determine if the source individual is willing to have his/her blood tested for HIV and HBV. If a source individual refuses testing, the refusal must also be documented on the Post-Exposure Form in the source individual information section. If the source individual agrees to testing, he/she shall be referred to an emergency room or a health...
practitioner of his/her choice for pre-test counseling. If a source individual is already known to be HIV, HBV, or HCV positive, new testing is not required.

Consent and record releases should be obtained by a licensed healthcare provider or other HIPAA-trained individual. **DO NOT ATTEMPT TO GAIN CONSENT FROM THE SOURCE INDIVIDUAL BY COERCION. THE SOURCE INDIVIDUAL IS NOT LEGALLY REQUIRED TO SUBMIT TO TESTING.**

6. As soon as it is feasible, assist the exposed employee in making arrangements to be seen by a health care practitioner. Note: for best results, prophylactic medicine if indicated should be administered within two hours. University employees have the option of being evaluated in an emergency room or by the physician of their choice.
**WORK-RELATED ACCIDENT/INCIDENT REPORT**

**Emergency Procedure:** Seeking Medical Treatment. Complete Steps 1 and 2
1. Call 911 if needed  
2. Call Campus Security 527-2222

**Non-Emergent:** Notify Human Resources by 527-2820 or email, the Day the accident or incident. Complete within 24 hours. Return by email HR@wallawalla.edu Fax: 527-2683 or in Person

Please Print

<table>
<thead>
<tr>
<th>Name: Last</th>
<th>First</th>
<th>MI.</th>
<th>Date of Birth</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Local Address: Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Phone No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee: ☐Faculty /Staff ☐Student</th>
<th>Department:</th>
<th>Job Title:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Were you doing your regular job at the time of incident? ☐Yes ☐No</th>
<th>Supervisor's Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of time on job: <em><strong><strong><strong><strong><strong>(years)</strong></strong></strong></strong></strong></em>(months)</th>
<th></th>
</tr>
</thead>
</table>

**Occupational Injury / Illness**

<table>
<thead>
<tr>
<th>Place of Accident:</th>
<th>Date &amp; Time of Accident</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How could this accident have been prevented?</th>
<th></th>
</tr>
</thead>
</table>

**FULLY DESCRIBE ACCIDENT:** If you fell, was it indoors or outdoors? If you were struck, name the object. Were you lifting, pulling, pushing or carrying? If machinery was involved, name and describe it’s function. Name chemical involved if appropriate.

<table>
<thead>
<tr>
<th>Nature of injury / illness and part of body affected: (Example: Cut to my right index finger / Cough due to inhalation of fumes)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Did you see a Health Care Provider? ☐Yes ☐No</th>
<th>Name of Hospital and/or Clinic:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you plan to see a Health Care Provider? ☐Yes ☐No</th>
<th>Name of Physician:</th>
</tr>
</thead>
</table>

**I acknowledge I’m aware or have been instructed to present to Human Resources for purposes of filing a workers’ compensation claim or information regarding claim filing. I’ve been advised of my rights under the Industrial Insurance Laws of the State of Washington. I’m aware I have one (1) year from the date of injury in which to file a claim.**

<table>
<thead>
<tr>
<th>Employee’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Witness to Accident (If No witness, write in NONE)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Supervisor’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Supervisor: Please also complete and attach an “Accident Investigation Report”**
# ACCIDENT/INCIDENT INVESTIGATION REPORT

Complete & Return to Human Resources within 72 Hours  
(Best to do the same time as page 1)

<table>
<thead>
<tr>
<th>NAME OF INJURED</th>
<th>DEPARTMENT</th>
<th>ACCIDENT DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPERVISOR / INSTRUCTOR’S NAME (Not Student)</td>
<td>SUPERVISOR / INSTRUCTOR’S TITLE</td>
<td>INVESTIGATION DATE</td>
</tr>
</tbody>
</table>

Check all factors contributing to the accident.

- [ ] HUMAN  
  - Training  
  - Task performance  
  - Work history

- [ ] SITE CONDITIONS  
  - Physical layout  
  - Walking/working surfaces  
  - Lighting  
  - Weather

- [ ] EQUIPMENT/TOOLS/MATERIALS  
  - Operation  
  - Safety guards and controls  
  - Condition and maintenance  
  - Labels/signs/tags

- [ ] TIME FACTORS  
  - Work shift  
  - Cause/effect relationships  
  - Sequence of events

- [ ] POLICIES AND PROCEDURES  
  - Safety Policies and Procedures  
  - Operating specifications  
  - Regulations and standards

- [ ] OCCUPATIONAL EXPOSURES  
  - Air contaminants  
  - Chemicals  
  - Noise  
  - Biohazards, human body fluids  
  - Radiation

- [ ] PERSONAL PROTECTIVE EQUIPMENT  
  - Was personal protective equipment required?  
    - [ ] yes  
    - [ ] no  
  - Was it provided?  
    - [ ] yes  
    - [ ] no  
  - Was it being used?  
    - [ ] yes  
    - [ ] no  
  
  If “NO” explain: ____________________________________________

  Was it being used as trained by supervisor or designated trainer?  
  - [ ] yes  
  - [ ] no  
  
  If “NO” explain: ____________________________________________

- [ ] OTHER

  ____________________________________________

  Explain all checked factors in the space below. Use back of page if needed.

List recommended corrective action. Use back of page if needed.

<table>
<thead>
<tr>
<th>Name of Person Responsible for Corrective Action</th>
<th>Department Responsible for Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated Date of Corrective Action</td>
<td>Actual Date of Corrective Action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPERVISOR / INSTRUCTOR’S SIGNATURE</th>
<th>DATE</th>
<th>EMPLOYEE SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCIDENT / SAFETY COMMITTEE SIGNATURE</td>
<td>DATE</td>
<td>DIRECTOR / CHAIR’S SIGNATURE</td>
<td>DATE</td>
</tr>
</tbody>
</table>
Name of Employee: __________________________________________
WWU ID: ____________________________
Department: ________________________________________________
Date of exposure: ___________________
Route of exposure: __________________________________________
Description of duties as they relate to exposure incident: ________________________
____________________________________________________________________
____________________________________________________________________
Circumstances under which exposure occurred: ______________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Has employee been immunized against hepatitis B?   ____Yes    ____No
   If yes, dates of immunization: ___________    ___________    ___________
   Series complete?   ____Yes    ____No

Note: As stated in WAC 296-62-08001, the employee has the right to a confidential medical
evaluation. At that time, the employee can consent to baseline blood collection and not give
consent for HIV serologic testing. The blood sample shall be preserved for at least ninety days,
during which time the employee can elect to have the baseline blood sample tested for HIV.

Name of source individual: _______________________________
Consent for testing HIV/HBV infectivity:   ____Yes    ____No
   If yes, refer source to health care professional for pre/post-test counseling.
   If not asked, state reason: ___________________________________________

Employee Signature _______________ Date _______________ Supervisor Signature _______________ Date _______________
WALLA WALLA UNIVERSITY BLOODBORNE PATHOGENS EXPOSURE

MEDICAL FILE REPORT

Health Care Professional’s Written Opinion

To be returned for employee’s confidential medical file at WWU Human Resources

1. Is a hepatitis B vaccination indicated?  ____Yes  ____No
2. Was HBV vaccination administered?  ____Yes  ____No
3. Was the employee informed of evaluation results?  ____Yes  ____No
4. Was HIV/HBV testing option counseling provided?  ____Yes  ____No
5. Was the employee counseled regarding any medical condition(s) which may require further evaluation or treatment?  ____Yes  ____No

ALL OTHER FINDINGS OR DIAGNOSES SHALL REMAIN CONFIDENTIAL AND SHOULD NOT BE NOTED ON THIS FORM

__________________________________________________
Name of Licensed Health Care Provider (print)

__________________________________________________
Signature of Licensed Health Care Provider

__________________________________________________
Date

WISHA requires that the above information be returned to the employer within 15 days of the evaluation

Return completed form to:

Walla Walla University
Human Resources
204 South College Ave.
College Place, WA 99324

06/2017
Chapter 296-823 WAC
Occupational Exposure to Bloodborne Pathogens
(Form Number 414-073-000)

LAST UPDATED: 01/20/2017

This book contains rules for Safety Standards for occupational exposure to bloodborne pathogens, as adopted under the Washington Industrial Safety and Health Act of 1973 (Chapter 49.17 RCW).

DATE: The new issue date of this book is January 2017. A brief promulgation history, set within brackets at the end of each section, gives statutory authority, administrative order of promulgation, and date of adoption of filing.

TO RECEIVE E-MAIL UPDATES:

• Sign up for our Listserv at www.Lni.wa.gov/main/Listsevts/SafetyStandards.asp

TO PRINT YOUR OWN PAPER COPY OR TO VIEW THE RULE ONLINE:

• Go to http://www.lni.wa.gov/Safety/Rules/Find/

TO REQUEST A HARDCOPY:

• E-mail your mailing address and book request to: RulesRequests@Lni.wa.gov

DOSH CONTACT INFORMATION:

• Physical address: 7273 Linderson Way, Tumwater, WA 98501-5414, located off I-5 Exit 101 south of Tumwater.
• Mailing address: DOSH Standards and Information, PO Box 44810, Olympia, WA 98504-4810
• Information telephone number is 1-800-423-7233

Also available on the DOSH web site:

| • DOSH Core Rules                  | • DOSH Regional Directives (DRD’s) |
| • Other General DOSH Rules         | • DOSH Interim Operations and Interpretive Memoranda (DIOIM) |
| • Industry and Task-specific Rules | • Memoranda of Understanding (MOU) |
| • Newly adopted Rules and New Rule Information | |
Chapter 296-823 WAC
Safety Standards for Occupational Exposure to Bloodborne Pathogens

LAST UPDATED: 01/20/2017

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