



# Healthcare Provider's Written Opinion

## Regarding Possible Occupational Exposure to Potentially Hazardous Body Fluids

This form, when completed, is returned to the DOC, as verification of employee contact with healthcare provider.

Institution/Functional Unit/Work Assignment (Print) \_\_\_\_\_  
 Describe Possible Exposure Incident: \_\_\_\_\_

Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

DOC Worksite Name and Address

Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Attn: Institution Safety Manager

Employee Name

(Print) \_\_\_\_\_ Employee ID No. \_\_\_\_\_

### CONFIDENTIAL REPORT FROM EXAMINING HEALTHCARE PROVIDER

In accordance with OAR 437.DIV 2. SUB Z. 1910.1030 BLOOD BORNE PATHOGENS.(f)1-5, the following information is being provided to the Department of Corrections for compliance purposes regarding the incident and employee identified above. Under paragraph (5) of the regulations, DOC "shall obtain and provide the employee with a copy...within 15 days" of the date below.

I. Information

- (A) We have access to a copy of the regulation cited above in print or on line,
- (B) The employee has described his/her duties as they relate to this incident,
- (C) The employee has described the incident and circumstances,
- (D) We have reviewed available laboratory tests,
- (E) We have or can request any other relevant medical records which it is DOC's Responsibility to initiate or maintain relative to this incident.

II. Written Opinion

- (A) Has the employee received hepatitis vaccinations? Yes No
- (B) Is Hepatitis vaccination indicated for this employee in this instance? Yes No
- (C) Has the employee been informed of the results of this evaluation? Yes No
- (D) Has the employee been told about any medical conditions resulting from exposure to BBP and other infections materials which warrant further evaluation or treatment? Yes No

**All other clinical findings are confidential**

III. DOC Employee Health Record

- (A) This information is retained by DOC in accordance with paragraph (h)(1) of 1910.1030

\_\_\_\_\_  
 Healthcare Provider's signature Date

\_\_\_\_\_  
 Print Name and Degree

NOTE: This form contains language specified in OR-OSHA regulation and becomes part of the employee's permanent health record.

Clinic/Office/Hospital Address or stamp