

# Bloodborne Pathogens Standard

29 CFR 1910.1030

## Sharps Injury Package

**INSTRUCTIONS:** Complete the forms in this package to report occupational injury with contaminated sharps.

**Contaminated** means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

**Contaminated Sharps** means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

<b>Sharps Injury Report</b>		
<b>NAME OF FORM</b>	<b>PAGE</b>	<b>ACTION</b>
Part 1 – Sharps Injury Report	1 – 2	1. Completed by employee 2. Employee receives a copy
Part 2 – Sharps Injury Report	3	1. Completed by Administrator 2. Employee receives a copy
Part 3 – Sharps Injury Report - Counseling	4	1. Completed by Health Care Professional Designated to Counsel Exposed Employee
Part 4 – Sharps Injury Report	5	1. Employee gives blank copy of this form to the physician 2. Completed by employee's medical provider and returned within 10 days unless employee completes the Declination Form
<b>Employee Declination of Post-Exposure Evaluation</b>		
Exposed Employee Declination to receive Medical Evaluation and Follow-up After an Exposure Incident	6	1. Completed by employee if refusing medical attention
<b>Identification and Evaluation of Source Individual (if known)</b>		
<b>NAME</b>	<b>PAGE</b>	<b>ACTION</b>
<b>Part A</b> – Identification and Evaluation of Source Individual	7	1. Completed by Site Administrator
<b>Part B</b> – Identification and Evaluation of Source Individual	8	1. Part A completed by Site Administrator 2. Part B completed by Medical Provider
<b>Employee's Exposure follow-up Record</b>		
<b>NAME</b>	<b>PAGE</b>	<b>ACTION</b>
Part A – Exposed Employee Follow-up Record	9	1. Completed by Employee
Part B – Employee's Exposure follow-up Record	10	1. Provide Employee with blank form to give to Medical Provider 2. Completed by Employee's Medical Provider
Exposure Incident Report Log	11	1. Completed and maintained by Site Administrator 2. Copy sent to OOSH

Bloodborne Pathogens Standard  
29 CFR 1910.1030

**Sharps Injury Report - Part 1**

**Please print all information**

EMPLOYEE DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:		Employee's First Name:
Date of Birth:	Social Security #	Home Telephone #:
EMPLOYEE HEPATITIS B VACCINATION STATUS		
Have you received the HBV vaccine? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date Dose #1 Received:	
If NO, Did you fill out an Employee Vaccination Form? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date Dose #2 Received:	
	Date Dose #3 Received:	
INCIDENT EXPOSURE		
Date of Exposure:	Time of Exposure: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Where Did The Incident Take Place?		
Where Did The Incident?		
Describe The Incident:		

**INCIDENT EXPOSURE**

Check <input checked="" type="checkbox"/> to Describe How The Exposure Occurred:	<b>AFFECTED BODY PARTS</b> Check <input checked="" type="checkbox"/> all That apply
<input type="checkbox"/> During use of sharp	<input type="checkbox"/> Finger
<input type="checkbox"/> Disassembling	<input type="checkbox"/> Arm
<input type="checkbox"/> While preparing to dispose of sharp	<input type="checkbox"/> Hand
<input type="checkbox"/> Sharp left in an inappropriate place	<input type="checkbox"/> Leg
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Other (Specify)

**IDENTIFICATION OF SHARP INVOLVED (IF KNOWN)**

Type:	
Brand:	
Model:	

**SUBMIT COMPLETED COPY TO:**

<input type="checkbox"/>	ISC Safety and Health Liaison (enter name and address)	<input type="checkbox"/>	New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682
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\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

This form and related documentation will remain confidential. Personal identifying information will be released with the employee's consent only.



Department of Education

Joel Klein  
Chancellor

**Confidential**

Completed by Site Administrator

Bloodborne Pathogens Standard  
29 CFR 1910.1030

**Sharps Injury Report - Part 2**

**Please Print All Information**

EMPLOYEE DEMOGRAPHICS		
Date:	Region:	District:
School Code (E.g. 123K):	Work Facility Name:	Work Telephone:
Employee's Last Name:	Employee's First Name:	
Date of Birth:	Social Security #	Home Telephone #:
INCIDENT REPORTING		
Is A Comprehensive Accident Report Detailing This Incident On file?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
Is An SH 900 and Related Documents Detailing this Incident On File?		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE		
If NO, or N/A, explain:		
SUBMIT COMPLETED COPY TO:		
ISC Safety and Health Liaison (enter name and address)	New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682	

\_\_\_\_\_  
Site Administrator's Signature

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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## Bloodborne Pathogens Standard

29 CFR 1910.1030

### Sharps Injury Report - Part 3

**NOTE** - OSHA's Bloodborne Pathogens Standard cited as 29 CFR 1910.1030 requires that post-exposure counseling be given to employees following an exposure incident. Counseling should include USPHS recommendations for transmission and prevention of HIV. These recommendations include refraining from blood, semen, or organ donation; abstaining from sexual intercourse or using measures to prevent HIV transmission during sexual intercourse; and refraining from breast feeding infants during the follow-up period. In addition, counseling must be made available regardless of the employee's decision to accept serological testing.

HEALTH CARE PROFESSIONAL	
Health Care Professional Name:	Title:
Office Location:	
Telephone:	Fax Number:
EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Home Address:	
Home Telephone:	Social Security #:
EXPOSURE INCIDENT	
Employee Job Description:	
Date of Exposure:	Date Exposure Reported:
Exact Location of Exposure:	
Type of Exposure:	
Source of Individual:	
Immediate Action Taken:	
Treatment Provided:	
Recommendation:	
Referral:	
Comments:	

\_\_\_\_\_  
Health Care Professional/Counselor Signature

\_\_\_\_\_  
Date

Bloodborne Pathogens Standard  
 29 CFR 1910.1030

**Sharps Injury Report - Part 4**

EXPOSED EMPLOYEE	
Employee's Last Name:	Employee's First Name:
Date of Birth:	Social Security #:
Work Site Name:	Work Telephone:
MEDICAL CARE PROVIDER	
Health Care Professional Name:	Title:
Address:	
Telephone:	Fax Number:
MEDICAL CARE PROVIDER'S REPORT	
Did You Treat The Patient/Employee Directly? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES, Specify Treatment Regimen:	
Other Pertinent Information:	

\_\_\_\_\_ Medical Care Provider's Signature

\_\_\_\_\_ Date

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Bloodborne Pathogens Standard  
 29 CFR 1910.1030

**Employee Declination of Post-Exposure Evaluation Form**

I was exposed to blood and other potentially infectious body fluids at my worksite on \_\_\_\_\_.  
 As a result of this incident, I have completed the required incident report and was advised by Administration to seek  
 medical evaluation and follow up by a Physician or Health Care Provider immediately. I decline medical evaluation.

Employee's Last Name:		Employee's First Name:	
Job Title:		Social Security #:	
Work Site Name:			
Work Site Address:			
Region#:	District:	Work Telephone:	

\_\_\_\_\_  
 Exposed Employee Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Site Administrator's Name

\_\_\_\_\_  
 Site Administrator's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Principal's Name

\_\_\_\_\_  
 Principal's Signature

\_\_\_\_\_  
 Date

**Bloodborne Pathogens Standard**  
29 CFR 1910.1030

**Identification and Evaluation of Source Individual - Part A**

EXPOSED EMPLOYEE		
Employee's Last Name:		Employee's First Name:
Date of Birth:	Social Security #:	Job Title:
Work Site Name:	Work Telephone:	Home Telephone:
MEDICAL CARE PROVIDER		
Health Care Professional Name:		Affiliation:
Address:		
Telephone:		Fax Number:
INCIDENT INFORMATION		
Date of Incident:		Name or Record Number or Source Individual:
<b>Check <input checked="" type="checkbox"/> the most appropriate:</b>		
<input type="checkbox"/>	Blood or Body Fluid Splashed into Mucus Membrane or non-Intact skin	
<input type="checkbox"/>	Contaminated Needle Stick Injury	
<input type="checkbox"/>	Other:	

Signature

Date

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

**DO NOT RETURN THESE FORMS TO THE SCHOOL. FORMS MUST REMAIN IN EXPOSED EMPLOYEE MEDICAL FILE**

**Bloodborne Pathogens Standard**  
29 CFR 1910.1030

**Identification and Evaluation of Source Individual - Part B**

**Part 1**

MEDICAL CARE PROVIDER	
Medical Care Provider's Name:	Affiliation:
Address:	
Telephone:	Fax Number:

**Part 2**

REPORT OF SOURCE INDIVIDUAL EVALUATION	
Return this report to the above named exposed employee's medical provider within 15 days of evaluation	
Testing of source Individual's Blood:	
<input type="checkbox"/> Consent Obtained <input type="checkbox"/> Consent Refused	
TEST RESULTS	
<b>Check <input checked="" type="checkbox"/> One</b>	
<input type="checkbox"/>	Evaluation of source individual evidenced to known exposure to bloodborne pathogens
<input type="checkbox"/>	Evaluation of source individual evidenced possible exposure to bloodborne pathogens. Medical follow-up recommended
<input type="checkbox"/>	Identification of source individual infeasible or prohibited by State or Local Law. State why:
Name/Affiliation of Person Completing This Report:	
Signature	Date

In accordance with applicable confidentiality laws, report results of the source individual's blood tests to the medical provider named above. The named medical provider will then inform the exposed employee. Do not disclose blood test findings to employer or designee. In addition, note: HIV related information cannot be released without the written consent of the source individual.

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**Bloodborne Pathogens Standard**

29 CFR 1910.1030

**Employee's Exposure Follow-Up Record - Part 1**

**Part 1**

EXPOSED EMPLOYEE INFORMATION	
Exposed Employee Name:	Date Completed:
Work Site Name:	Work Site Address:
Job Title At Time of Exposure:	
Date of Exposure:	Time of Exposure:
SOURCE INDIVIDUAL FOLLOW-UP	
Name of Source Individual:	
Request Made To:	Date:
SUBMIT COMPLETED COPY TO:	
<input type="checkbox"/> ISC Safety and Health Liaison (enter name and address)	<input type="checkbox"/> New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

\_\_\_\_\_  
 Employee's Signature

\_\_\_\_\_  
 Principal's Signature

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**Bloodborne Pathogens Standard**

29 CFR 1910.1030

**Employee's Exposure Follow-Up Record - Part 2**

EXPOSED EMPLOYEE	
Name/Affiliation:	
Employee's Health File Reviewed <input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Blood Sampling/Testing Offered/Completed <input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Vaccination Offered/Issued: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Counseling Offered: <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOURCE INDIVIDUAL BLOOD TESTING	
<input type="checkbox"/> Results made available to employee. Employee has been informed of medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation and treatment.	
<input type="checkbox"/> Consent not obtained	
SUBMIT COMPLETED COPY TO:	
<input type="checkbox"/> ISC Safety and Health (enter name and address)	<input type="checkbox"/> New York City Department of Education Office of Occupational Safety and Health 65 Court Street, Room 706 Brooklyn, NY 11201 Tel: 718-935-2319 Fax: 718-935-4682

\_\_\_\_\_  
 Medical Care Provider's Signature

\_\_\_\_\_  
 Employee's Signature

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Calendar Year:

## Bloodborne Pathogens Standard – Sharps Injury Log

This form is required by OSHA’s Bloodborne Pathogens Standard 1910.1030 and must be kept in the facility for 5 years. Failure to maintain this log can result in the Issuance of Notice of Violation and Order to Comply. Use this form to log injures from contaminated sharps. Information provided on this form must be recorded and maintained in such a manner as to protect the confidentiality of the injured employee. Forward completed form at the end of each calendar year to: The Office of Occupational Safety and Health, 65 Court Street, Room 706, Brooklyn, NY 11201.

Facility Name:	Principal's Name:
Facility Address:	Facility Phone:

#	DATE OF EXPOSURE	TYPE OF SHARP INVOLVED (IF KNOWN)	BRAND/MODEL OF SHARP INVOLVED	PLACE OF INCIDENT	TASKS BEING PERFORMED AT TIME OF INCIDENT	DESCRIPTION OF EXPSOURE
1.						
2.						
3.						
4.						
5.						