BLOOD BORNE PATHOGENS INJURY REPORT FORM

Date: Time: Building: Room:

Name of injured: Student/Faculty ID:

Email of injured: Phone #:

Name of PI/Supervisor: Email:

Name of witness: Email:

Date of incident: Time of incident:

Please check one:

☐ Student
☐ Employee/Student employee

Please check one:

☐ Needle ☐ Syringe ☐ Glass ☐ Other

If other please specify:

Please check one:

☐ Medical Services Requested ☐ No Services Requested

If requested, which hospital:

Describe the incident as it occurred (use back if necessary):

_____
Signature of injured Date

_____
Signature of witness Date

_____
Signature of PI/Supervisor Date