

# CALIFORNIA STATE UNIVERSITY, FULLERTON

## POST-EXPOSURE EVALUATION AND FOLLOW-UP FORM

As part of my employment with California State University, Fullerton, I may have been exposed to blood or potentially infectious materials on the following date: \_\_\_\_\_ Injured Employee's Name: \_\_\_\_\_  
The route of exposure was: \_\_\_\_\_  
The name and address of the source individual is: \_\_\_\_\_

- Exposure Incident Report Form has been completed (*copies forwarded to EH&IS and Human Resources*)
- Source Individuals blood has been tested (*provided consent obtained*)
- Exposed employee has been notified of result

I further understand that as a result of this exposure I may require evaluation or treatment due to the potential risk of acquiring Hepatitis B virus, HIV or other bloodborne infection. I was offered and encouraged to have a confidential medical evaluation and follow-up and have been given the opportunity to be vaccinated with Hepatitis B vaccine and/or Hepatitis B Immune Globulin at no charge to myself. \_\_\_\_\_  
*initial*

Please check the following that apply:

- I accept the Hepatitis B vaccination series.
- I accept the Hepatitis B Immune Globulin.
- I decline the Hepatitis B vaccination series.
- I decline the Hepatitis B Immune Globulin.
- I consent to baseline blood collection and HBV serological testing.
- I do not consent to baseline blood collection.
- I consent to baseline blood collection but do not consent to any testing at this time. I understand that the blood sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, I elect to have baseline samples tested for either HBV or HIV, such testing shall be done as soon as feasible.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME (PLEASE PRINT)

\_\_\_\_\_  
DEPARTMENT

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

