

HEALTH CARE PROFESSIONAL'S WRITTEN OPINION FOR POST-EXPOSURE EVALUATION

Employee's Name:
Date of Incident:
Date of Evaluation:
Health Professional's Address:
Health Professional's Telephone Number:

___ The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.

___ The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

___ Hepatitis B vaccination is ___ is not ___ indicated.

Health Care Professional's Name

Health Care Professional's Signature

Date

Return this form to the employer and provide a copy to the employee within 15 days of receipt. Please label the outside of the envelope "Confidential." Thank you.

Facility Name: _____

Facility Address: _____

Confidential Fax: _____