

# City of Somerset

## EXPOSURE / SHARPS INCIDENT REPORT

**NOTE: Completely fill this report out for each employee incident in addition to the Incident Report.**

Name: \_\_\_\_\_ Department: \_\_\_\_\_  
 Date of Incident (mm/dd/yy): \_\_\_\_\_ Time of Injury (24 hour: hh:mm): \_\_\_\_\_  
 Gender:        Male                Female                Date of Birth (mm/dd/yy): \_\_\_\_\_  
 Date Submitted (mm/dd/yy): \_\_\_\_\_ Supervisor: \_\_\_\_\_  
 Description of the exposure incident (include PPE in use at time of exposure):  
 \_\_\_\_\_

**FOR SHARPS INCIDENT, COMPLETE ALL SHADED AREAS.**

Procedure Being Performed at Time of Incident: (Check All That Apply) Draw venous blood                Cutting Heparin/saline flush                Suturing Draw arterial blood                Injection through skin Start IV/set up heparin lock Handle medical waste Provide First Aid/CPR Other:	Incident Occurred: (Check All That Apply) During use of sharp Disassembling Between steps of a multistep procedure After use and before disposal of sharp While putting sharp into disposal container Sharp left in inappropriate place (table, bed, trash, etc.) Other:		
Body Part: (Check All That Apply) Finger Face/Head Hand Torso Arm Leg Other:	Identify sharp involved (if known): Type: Brand: Model: Lot No.:  (EXAMPLE: "18ga. needle", "ABC Medical", "no stick syringe", "lot #101")	Did the device being used have engineered sharps injury protection? Yes                No Don't know	Was the protective mechanism activated? Yes, Fully Yes, Partially No
		Did the exposure incident occur? Before Activation During Activation After Activation	

**Sharps Incident Employee Opinion:** If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the incident?        Yes        No  
 Explain:

**Exposure Incident Employee Opinion:** Do you have an opinion that any other engineering, administrative or work practice control could have prevented the incident?        Yes        No  
 Explain:

Did employee: Seek medical attention?    Yes        No                Call Co. Nurse?:    Yes        No  
 Health Care Facility: \_\_\_\_\_                Facility Phone No.: \_\_\_\_\_

**IMPORTANT: MAKE SURE "OUTLOOK" IS STILL OPEN.**

\*\*\* REVIEW YOUR FORM, THEN CLICK ON THE LARGE RED BUTTON AT RIGHT TO EMAIL TO THE H.R.MANAGER & SAFETY COORDINATOR.

\*\*\* PLEASE COPY YOUR DEPARTMENT MANAGER IN YOUR EMAIL.