Medical Student Exposure Incident Form

Date of Report: ________________________

Student Name: ______________________________________________________________

Academic Year (ex. M1, M2, M3, M4; PGY-1, PGY-2, etc.): __________________

Date of Exposure Incident: ________________________________________________

Z #: __________________________________________________________

Location of Occurrence (Name of healthcare facility.): ___________________________________________

Name and telephone number of Immediate Supervising Physician: ____________________________

Potentially Infectious Materials Involved: ___________________________________________

(Blood, body fluid, etc.)

Identify the route of exposure (skin, eye, mucous membrane, etc.):______________

Describe the task being performed at the time of the exposure:___________________________

To whom has the incident been reported? ________________________________

Mandatory Reporting of Incident to FAU COM Office of Student Affairs within 24 hours of the exposure incident:

Name of Student Affairs Dean contacted and date reported: ________________________________