

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS
(THIS IS NOT A CLAIM FORM)

1. **Name**
Last _____ First _____ M.I. _____ Social Security No. _____
Birth Date _____
Phone No. _____

2. Address _____ City _____ State _____ Zip _____

3. Employer's or Firm's Full Name _____ Employer's or Firm's Phone No. _____

4. Employer's or Firm's Address _____

5. Date of Exposure _____ Time of Exposure _____ A.M. P.M.

6. Address or Location of Exposure _____

7. Job Title _____

8. State fully how exposure occurred (be specific) _____

9. List all persons present at the exposure whom you can identify _____

10. What bodily fluid were you exposed to?
Blood Vaginal Fluid Any other fluid(s) containing blood (describe) _____
Semen Surgical fluid(s) _____

11. Who did the bodily fluid come from? _____
(Explain) _____

12. Are you aware of a break/rupture in the skin or mucous membrane at body location of exposure to bodily fluid and if so, please describe. _____

13. Did exposure to bodily fluid take place through your (a) skin (b) mucous membrane?

14. What specific part(s) of your body was exposed to bodily fluid? _____

15. **NOTE:** THIS REPORT MUST BE FILED WITH YOUR EMPLOYER NO LATER THAN (10) CALENDAR DAYS OF YOUR WORK EXPOSURE TO BODILY FLUIDS.

OTHER REQUIRED STEPS:

A. YOU MUST HAVE BLOOD DRAWN NO LATER THAN TEN (10) CALENDAR DAYS AFTER EXPOSURE.

B. YOU MUST HAVE BLOOD TESTED FOR HIV BY ANTIBODY TESTING NO LATER THAN THIRTY (30) CALENDAR DAYS AFTER EXPOSURE AND TEST RESULTS MUST BE NEGATIVE.

C. YOU MUST BE TESTED OR DIAGNOSED AS HIV POSITIVE NO LATER THAN EIGHTEEN (18) MONTHS AFTER THE EXPOSURE.

D. YOU MUST FILE A WORKERS' COMPENSATION CLAIM WITH THE INDUSTRIAL COMMISSION OF ARIZONA NO LATER THAN ONE YEAR FROM THE DATE OF DIAGNOSIS OR POSITIVE BLOOD TEST IF YOU WISH TO RECEIVE BENEFITS UNDER THE WORKERS' COMPENSATION SYSTEM.

I HAVE FILED THIS FORM WITH MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETED FORM.

EMPLOYEE SIGNATURE _____ DATE _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA
FOR CARRIER USE

1 COPY FOR EMPLOYER
SEND 1 COPY TO EMPLOYEE
SEND 1 COPY TO INSURANCE ADMINISTRATOR:
SOUTHWEST RISK SERVICES • 4835 E. CACTUS ROAD, SUITE 360 • SCOTTSDALE, AZ 85254-3543