EXPOSURE CONTROL PROCEDURES (NEEDLE STICK)

Employees and students at WITC recognize that even with strict adherence to standard precautions and exposure prevention practices, exposure incidents may occur. WITC has an exposure control plan in place to assure appropriate and timely post-exposure follow-up.

a. The involved student will report the incident immediately to their onsite supervisor. By the end of the day the Program Director and the WITC College Health Nurse must be contacted.
b. If the incident occurs at a clinical site, clinical agency policy is implemented first.
c. WITC Accident/Injury Report Form is completed and given to the WITC Health Nurse and Program Director.
d. The College Health Nurse follows the WITC Exposure Control Plan.
e. The College Health Nurse collaborates with the student and program staff as needed.
f. The College health nurse provides completed documentation to the Dean, Allied Health and Nursing.

WISCONSIN INDIANHEAD TECHNICAL COLLEGE

Accident/Injury Report

WITC Safety Office *** 715.468.2815 or 800.243.9482, Ext. 2256
Fax: 715.468.7063; safety@witc.edu

General Information

Today's Date: _____   WITC Location: _____

Name of Injured: _____

Address of Injured: _____

_____

Home/Cell Phone #: _____

Date of Birth: _____

Status of Injured (check one)

☐ WITC Employee   ☐ WITC Student   ☐ Visitor

☐ Other (specify): _____

Employee ID#: _____   Student ID#: _____

If employee, was any work missed?   ☐ Yes   ☐ No

Will any work be missed due to the accident?   ☐ Yes   ☐ No

Accident/Injury Details

Date of Accident/Injury: _____   Time: _____ ☐ a.m. ☐ p.m.

Specific location where injury occurred: _____

Name(s) of other individual(s) involved: _____

Witness(es) (Name and phone number): _____

(Witness(es) may be asked to complete Accident/Injury Witness Report if they do not do so right away)

Describe activity prior to the incident: Click or tap here to enter text.

Describe exactly how the accident/injury occurred: Click or tap here to enter text.

What part of your body was injured? _____

Have you ever injured this part of your body before?   ☐ Yes   ☐ No

If yes, when? _____

Specify machine, tool, substance, or object connected with the accident/injury: Click or tap here to enter text.

Unsafe mechanical/physical/environmental condition at time of accident (be specific): Click or tap here to enter text.

What could prevent this type of incident from occurring again? Click or tap here to enter text.

Initial Treatment (check all that apply)

☐ No Medical Treatment

☐ Seen by College Health Nurse (notes sent to Safety Office under separate cover)

☐ Clinic/Hospital/Emergency Room

☐ Hospitalized overnight

☐ Future major medical/lost time anticipated

☐ Went home

☐ Returned to work

Treating Clinic/Hospital/Physician (Name and Address):

_____

_____   _____
Signature of person injured or in accident OR   Signature Date
Signature of person completing form on injured person's behalf

The Safety Office will notify your supervisor/dean, Campus Administrator, and Vice President of this accident/injury as appropriate.

6/30/2010 Revised: 6/2014, 10/2017, 1/2018

Significant Exposure Description
Form A

Section I.	**Exposed Person Data (exposed person completes)**

Name: _____   Phone #: _____

Address: _____

Date of exposure: _____   Location: _____

☐ Student   Program area: _____

☐ Employee   Division: _____

Section II.	**Description of Exposure (completed by Instructor/Staff)**

Type of Exposure:

☐ Blood-body fluid into body orifice (e.g., nose, mouth)
☐ Blood exchanged from penetrating wound, including needle puncture
☐ Human bite where skin is broken
☐ Blood/body fluid exposure—mouth-to-mouth resuscitation

Type and estimated volume of fluid exchanged: _____

Anatomical site exposed: _____

Specific description of incident: _____

_____

Section III.	**Source Person Data**

Client Name: _____

Address: _____

Name of Physician, Hospital, Clinic: _____

Diagnoses: _____

The above is an accurate description of the exposure. Disclosure to the exposed person of the source person's HIV/Hepatitis B/Hepatitis C test results is requested.

Exposed person: _____   Date: _____

Instructor/Staff: _____   Date: _____