TRINITY

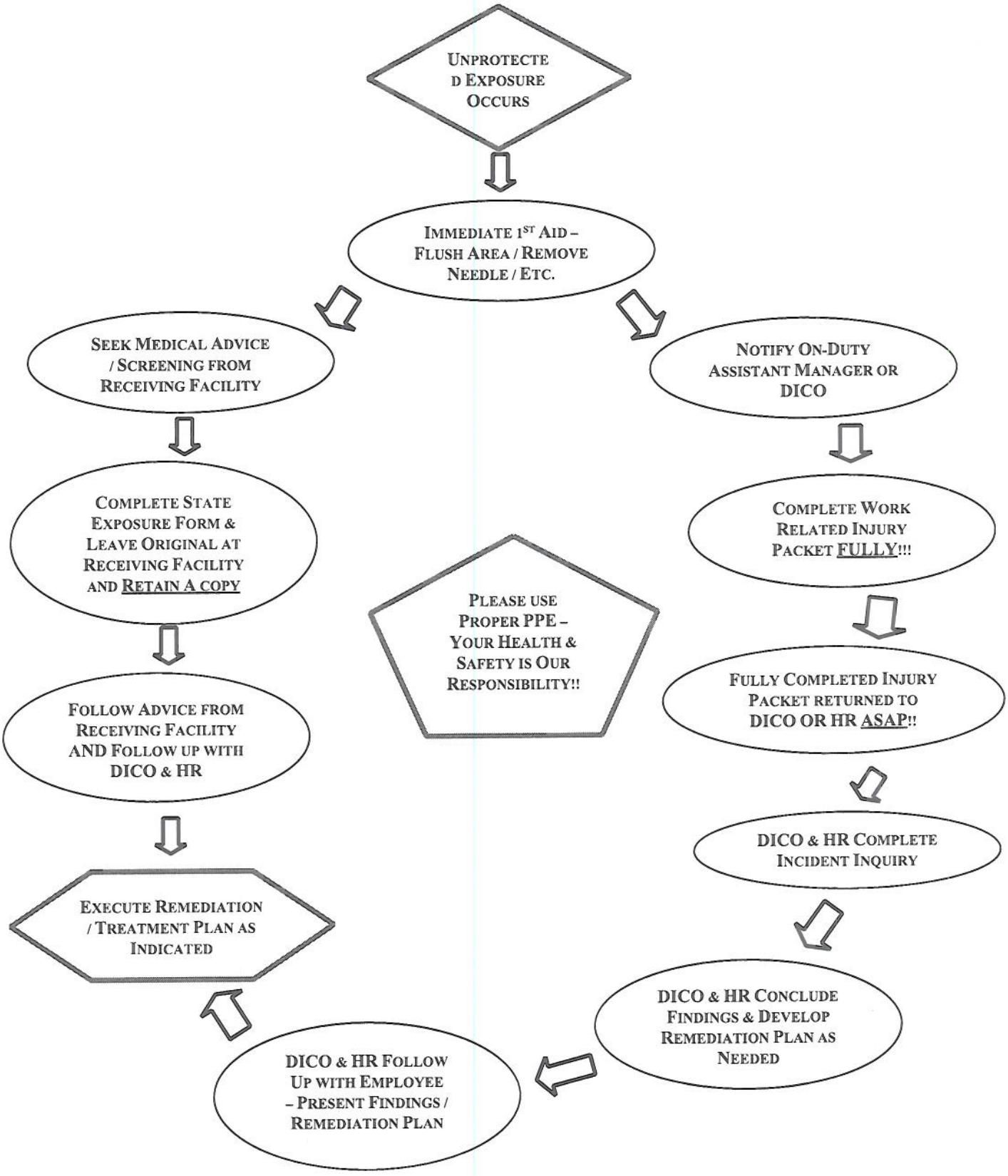
EMERGENCY MEDICAL SERVICE

Unprotected Exposure Packet

New Hampshire

Please complete the enclosed documents, follow the Exposure Flow Chart, and return the appropriate completed documents to the Human Resource Manager. This will facilitate your evaluation, treatment if necessary, and claims processing.

CHAPTER E: APPENDIX
SECTION 10 – UNPROTECTED EXPOSURE FLOW CHART



New Hampshire Department of Safety
Bureau of Emergency Medical Services
33 Hazen Drive Concord, NH 03305
1-888-827-5367

EMERGENCY RESPONSE/PUBLIC SAFETY WORKER INCIDENT REPORT FORM

(Completed by Exposed Worker at time of the incident)

Exposed Worker Category: Emergency Care Provider: ___ Police/Corrections Officer: ___ Firefighter: ___

Exposed Worker Name: _____ **Date of Incident:** _____ **Time of Incident:** _____

Home Address: _____
Street Town State Zip

Telephone: Work: (978) 441-9191 **Home:** _____ **Cell:** _____

Medical Referral Consultant: Name _____ **Telephone** _____

Address: _____
Street Town State Zip

Name of Employer: Trinity EMS, Inc. Company Infection Control Officer: Kirk Brigham 978-551-2393

Exposed Worker's Private Physician: _____ **Telephone:** _____

Address: _____
Street Town State Zip

Incident Source Individual's Name: _____ **Sex:** M___ F___

Healthcare Facility Receiving Incident Source Individual (if applicable): _____

Facility Address: _____

Healthcare Facility Infection Control Officer: _____

Incident Source Individual's Physician: _____

Exposure Description: (check each that apply)

A. Blood or Other Body Fluids
   1. ___ Blood or other body fluids into natural body openings (nose, mouth, eye).
   2. ___ Blood or other body fluids into non-intact skin (e.g. cut, burn, abrasion).
   3. ___ Needlestick with contaminated needle or other sharp instrument.
   4. ___ Other (describe) _____

B. Respiratory
   1. ___ Mouth-to-mouth resuscitation.
   2. ___ Resuscitation using airway.
   3. ___ Other (describe) _____

Type of fluid to which you were exposed (check each that apply)
   1. ___ Blood
   2. ___ Respiratory Secretions
   3. ___ Other (describe) _____

Describe any action take, and when, in response to the exposure to remove the contamination (e.g. hand washing):

_____

What protective measures were being taken at the time of exposure (e.g. wearing gloves, goggles):

_____

Any other information related to the Exposure: _____

_____

I hereby consent to the release of this information to the incident source individual's physician, the healthcare facility, and to the N.H. Division of Public Health Services.

1 Copy to:

__ Medical Referral Consultant __ Infection Control Officer __ Exposed Worker __ NH Bureau of EMS

New Hampshire Department of Safety
Bureau of Emergency Medical Services
33 Hazen Drive Concord, NH 03305
1-888-827-5367

Signature of Exposed Worker: _____ Date: _____

1 Copy to:

__ Medical Referral Consultant __ Infection Control Officer __ Exposed Worker __ NH Bureau of EMS

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First Report of Injury – Employee Guidelines

Explanation of Employee obligations when reporting a work related injury:

_____ You must be seen at one of the following facilities – unless less threatening then go to closest Emergency Department or if infectious disease exposure then go to Emergency Department of the source patient receiving facility.

_____ Lowell General Hospital's Occupational Medicine, Lowell General Chelmsford Campus located at 10 Research Place, Suite 200, in Chelmsford, MA. **Phone:** 978-458-6868 Monday-Thursday 8:00am-6:00pm, Friday 8:00am-4:00pm

_____ Salem Occupational Acute Care of Salem; (603) 898-0961, located at 22 Main St. Salem, NH. if injured Monday through Friday 0800 – 1700 hr. NOTE – Tuesday & Friday closed at 1600 hr.; otherwise report to Holy Family Emergency Department - ****follow up at Salem Occupational Acute Care the next business day**.

_____ If you are seen at an Emergency Department, due to the primary facility is closed or the injury occurred during non-business hours, you must make a follow-up appointment with the corresponding occupational health facility the next business day.

_____ You may follow up with your own physician after being seen by one of the above facilities.

___ If this injury results in lost-time from work exceeding 5 days, a representative from our workers compensation insurance company will contact you.

___ During the State's 5-day waiting period of lost-time claim, your wages will be paid with available PTO time. Beyond 5 days, your lost wages will be paid by the workers compensation carrier at the State's allowed rate based on your past 12-month wages.

___ This package must be completed in its entirety and submitted to a Supervisor or Manager no later than 24-hours from the time of injury. Failure to follow the guidelines listed may result in a denial of your claim.

___ You must supply the Human Resources Department with all doctor's pertaining to your injury.

___ If your injury results in modified work duty, you must be available to work any and all modified duty assignments.

___ You must provide Human Resources a doctor's note releasing you for full duty without restrictions prior to returning to work.

___ You must keep in contact with Human Resources weekly in the event of a lost time injury.

___ By signing below and initialing next to each item above, you as an employee of Trinity EMS, Inc. acknowledge that you have read and will abide by the guidelines outlined in this package. You also acknowledge that failure to comply with any or all of the guidelines may result in termination of workers compensation benefits or a denial of your claim.

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_____ _____
Employee Signature Date

WORKER'S COMPENSATION ACCIDENT REPORT

ACCIDENT REPORT: to be completed by a Supervisor and the injured employee immediately. The Supervisor is to suggest treatment of injury at one of the designated facilities.

Employer's Name: **Trinity EMS, Inc.**

Check Treatment: ___ First Aid Only ___ Healthcare Facility

Injured employee sent to:

___ Lowell General Occupational Health ___ SMC Emergency Department

___ Salem Occupational Acute Care ___ Holy Family Emergency Department

___ Other: _____

Date of this Report: _____ Date of Accident/Injury: _____

Time of Accident/Injury: _____ AM / PM (circle one) Date of Hire: _____

Employee's Name: _____ **Date of Birth:** _____
First Middle Last

Employee Address: _____ **Tel. #:** _____
No & Street City State Zip

Marital Status: ____ Single ____ Married **SSN#:** _____

Number of Dependents under 18 years of Age: _____ Job Title: _____

Supervisor: _____ Sup. Tel. #: _____

Circle Normal Work Days: S – M – T – W – T – F – S **Schedule Hours per Week:** _____

Describe injury & body part inured: _____

Where did injury take place (be specific): _____

How did injury occur – explain all facts: _____

Causes: What causes, failures to act, or conditions contributed directly to this accident/injury?

Action Plan: What will be done to prevent similar loss? _____