

APPENDIX A

SAMPLE FORMS

Authorization for Disclosure Consent for HBV/HCV Antigens, HIV Antibody Documentation of Staff Education Employees Eligible for Hepatitis-B Vaccination Hepatitis-A Consent Hepatitis-B Consent Hepatitis-B Declination Hepatitis-B Titer Hepatitis-B Vaccine Immunization Record Hepatitis-B Vaccine Series Post-Exposure Investigation Post-Exposure Report Post-Exposure Procedure Sharps Injury Log Source Individual Consent **Training Sign-In** Training Health-Tech Vaccine Requests



AUTHORIZATION FOR DISCLOSURE

This authorization and consent for use or disclosure of the results of a blood test to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV) or Hepatitis-B Virus (HBV) or Hepatitis-C (HCV) is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Civil Code section 56 <u>et seq</u>., the Information Practices Act, Civil Code section 1798 <u>et seq</u>., Health and Safety Code section 199.21 (g), Education Code section 49076 where applicable, and Article I, section 1 of the California Constitution.

I,	 , hereby	authorize:

and to

(Title or Name of Designated Representative of School District to Which Disclosure of Medical Information Was Made)

(Health Care Provider)

To furnish to: _____

(Name or Title of Person to Receive Information.)

the results of my blood test to determine the presence of HIV antibodies or the Hepatitis B Virus.

The person(s) receiving this information may use the information for any purpose, subject only to the following limitations:

This authorization and consent shall be come effective immediately, and shall remain in effect indefinitely, or until: Date ____/____

I understand the person(s) identified above, receiving the information identified above, may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

Date

Signature

Printed Name

Parent/Guardian's Signature if Minor

Printed Parent/Guardian's Name



CONSENT FOR HBV /HCV ANTIGENS AND HIV ANTIBODY BLOOD TEST

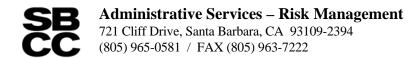
I have been requested because of a recent incident to have my blood tested for HBV / HCV antigens and HIV antibodies. I understand that an individual has been exposed and may be at risk for Hepatitis B (HBV), Hepatitis C (HCV) or AIDS virus (HIV) infection.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment and the exposed employee.

I have been informed that if I have any questions regarding the nature of the blood test, it's expected benefits, its risks, and alternative tests, I may ask those questions before I decide to consent to the blood test.

I will have the blood test as soon as feasible in order to determine HBV / HCV or HIV infectivity.

Printed Name		Social Security	#	
Address	City	State	Zip	
()				
Phone				
Signature			Witness	
/ /		/	/	
Date		Da	ite	



EXPOSURE CONTROL PLAN BLOODBORNE PATHOGENS

DOCUMENTATION OF STAFF EDUCATION

Employee Name	Job Title	Department	
Date of Training	Instructor's Name		
ΤΟΡΙϹ		Reviewed (x)	
 Epidemiology/Symptoms/Modes The Infection Control Program an a. Hand washing Universal Precautions c. Isolation techniques 	of transmission of HIV / HBV / HCV infections d Manual, including:		
 The exposure control program Recognition of activities that can How to prevent/reduce exposure: Engineering Controls Work Practices Personal protective equipment 	ent:		
 proper use, removal, handling storage locations, how to se 6. Hepatitis B Vaccine - efficacy, sat 7. Emergencies - persons to contact 8. Exposure incidents - incident reports counseling at no cost 9. Labels, signs, and color coding 10. Infections, spills - cleanup and res 11. Infectious waste handling 12. Handouts given 	ety, benefits, adverse reactions t and actions to take ort, medical follow-up and		
12. Handouls given			

The above has been reviewed with me, I am satisfied that I have a good understanding of its contents, and I had ample opportunity to have my questions answered.

_/___/____ Date Employee Signature

The above has been reviewed with the employee and I certify that at the conclusion of the training the employee had an adequate understanding of the program's contents.

	/	/
Instructor's Signature	Date	



Administrative Services – Risk Management 721 Cliff Drive, Santa Barbara, CA 93109-2394 (805) 965-0581 / Fax (805) 963-7222

EMPLOYEES ELIGIBLE FOR HEPATITIS-B VACCINATION

EMPLOYEE	DEPT.	CONSENT/ DECLINE	TRAINING DATE	INO #1	CULA' #2	ΓΙΟΝ #3	COMMENTS



Hepatitis-A Consent

The MedCenter Santa Barbara CA 2945 State Street (805) 6827411

is an employee at Santa Barbara City College. He/she is authorized for Hepatitis A vaccine series. Please forward the vaccine record via FAX to Risk Management, Attention: Steven Lewis, Risk Manager. *Please bill invoice to Steven Lewis, Administrative Services.*

Risk Manager Signature

Date

I authorize the release of the Hepatitis A vaccine records to Santa Barbara City College Student Health Services. I further give permission for the medical care providers at the MedCenter to confer with the Risk Manager, Administrative Services regarding the records.

Employee Signature

Date



Hepatitis-B Vaccine Consent

Hepatitis-B is caused by the Hepatitis-B virus which is transmitted by coming in contact with contaminated blood or body fluids through a needle puncture, a break in the skin or contact with mucosal surfaces (eyes, mouth, genital tract). The lifetime risk of Hepatitis B is about 5% for the general population. Health care workers however, have an increased risk (up to 20% over a lifetime) because of frequent blood exposure. Most people with Hepatitis B recover completely, but 1-2% die and 5-10% become chronic carriers of the virus. Chronic carriers may have no symptoms or may have chronic liver disease leading to cirrhosis. An association has also been demonstrated between Hepatitis B carriers and liver cancer.

Hepatitis-B vaccine (Recombivax-HB) is a non-infectious vaccine derived from Hepatitis-B antigens produced in yeast cells. The current vaccine is free of association with human blood or blood products. Tests of the vaccine in humans have demonstrated development of protective antibodies in 90% of those vaccinated with the full series of three doses. *The vaccine series consists of the three injections given at 0, 1 and 6-month intervals.* The duration of the antibody protection is unknown. As with all immunizations there is no guarantee that immunity will develop.

No serious side effects have been associated with the vaccine, however, as with any drug, there is a slight possibility of an allergic reaction. Mild soreness and redness at the injection site may occur. Fever, nausea, rash, headache, fatigue and joint pain have been reported.

Recombivax-HB is contraindicated in the presence of hypersensitivity to yeast. Any serious active infection is reason for delaying use of the vaccine except when withholding the vaccine entails a greater risk. The vaccine will be given to pregnant women only if clearly needed and as recommended by her physician.

I have been trained regarding bloodborne pathogens and possible exposure to Hepatitis-B. I have read the above statement about Hepatitis-B and the vaccine. I understand the benefits and risks involved. *I understand that I must have all three doses of the vaccine to confer immunity*. I acknowledge that I have 30 days to complete the first injection or sign the Hepatitis-B Declination Form. If after 30 days I have not received the first injection or have not signed the Hepatitis-B Declination Form, my supervisor will be notified.

I request that the Hepatitis-B vaccine series be given to me.

Print Name

Department

Signature

Date

Witness

Date

Please return completed form to Risk Manager, Administrative Services



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Hepatitis B Vaccination Declination Form

Employee Name

Social Security #

Department

I understand that due to my occupational exposure to blood or other potential infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can request and receive the vaccination series at no charge to me.

_____ I have received the Hepatitis B vaccine series or have had Hepatitis B. Initial

Dates of vaccine series: _____

Other Comments:

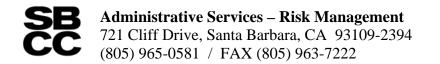
Employee Signature

Date

Witness

Date

Please return this form to Risk Manager, Administrative Services



HEPATITIS B TITER

The MedCenter, Santa Barbara CA2945 State Street682-7411319 N. Milpas Street965-3011

is an employee at Santa Barbara City College. By OSHA standards on bloodborne pathogens, he/she is eligible for Hepatitis vaccine series. Before receiving the series this employee has requested a Hepatitis B titer. Please forward the results to Risk Management, Attention: Steve Lewis, Risk Manager.

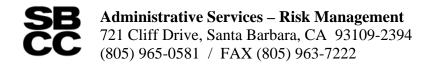
Risk Manager Signature

Date

I authorize the release the release of the Hepatitis B titer results to Santa Barbara City College Health Services. I further give permission for the medical care providers at the MedCenter to confer with the Risk Manager, Administrative Services regarding the results.

Employee Signature

Date



HEPATITIS B VACCINE SERIES

The MedCenter, Santa Barbara CA2945 State Street682-7411319 N. Milpas Street965-3011

is an employee at Santa Barbara City College. By OSHA standards on bloodborne pathogens, he/she is eligible for Hepatitis B vaccine series. He/she is unable to attend the scheduled SBCC vaccine clinics and will need to receive the vaccine at the MedCenter. Please forward the vaccine record to Attention: Steve Lewis, Risk Manager.

Risk Manager Signature

Date

I authorize the release of the Hepatitis B vaccine records to Santa Barbara City College Administrative Services. I further give permission for the medical care providers at the MedCenter to confer with Risk Manager, Administrative Services regarding the records.

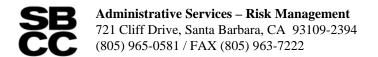
Employee Signature

Date



BLOODBORNE PATHOGEN POST-EXPOSURE INVESTIGATION FORM

Date of Incident:		Time of Incide	ent:: _		_AM / PM	
Name of	Exposed Employee:					_
Potential	ly Infectious Materials	Involved:				
Туре:	(i.e.: blood or OPIM)	Source:	lle bandages	bleedi	ng wound)	
	e Circumstances:		-		-	
	Incident:					
	Protective Equipment I	-				
<u>Source I</u> If Knowi	<u>ndividual Identity</u> : K n:	nown Unkno	own			
	. Consent for bloo Blood Collected	d test obtained	Date: Date:	/	/	
2	Consent not obta	ined	Date:	/	/	
	Verified by: (nar	ne) Medical Professio				
	Comment:					
3	Known Hepatitis	itive: Yes No -B positive: Yes -C positive Yes	No			
4	Results of Source	e individual's bloo	d test made av	vailable	to exposed en	nployee:
	Date:/	_/				



BLOODBORNE PATHOGEN POST-EXPOSURE REPORT FORM

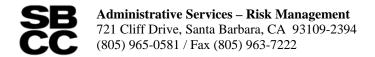
Employee Name:		
Date of Exposure Incident://	_ Time of Incident:	_: AM or PM
(Name of Healthcare F	Provider)	
Employee previously vaccinated against HBV infection	: Yes: No:	_ Date://
Description of employee's duties during the exposure in		
The route of exposure was: Needle stick with contaminated needle to :		
Piercing of skin with contaminated sharp to:		
Splashing/spraying of blood or other potentially infection	ous material to:	
Other:		
The circumstances under which exposure occurred are (describe):	
Personal protective equipment being used:		
The source individual is known:YesNo		
If known, is known to be infected with HBV	HIVHCV	
Request form for blood testing obtained: Yes	No	
The following remedial action may minimize the likelih	ood of future exposure:	

Signature of Program Coordinator/Health Services Nurse



BLOODBORNE PATHOGEN POST-EXPOSURE PROCEDURE

Employee:	Must report occurrence of an occupational exposure incident to supervisor as soon as possible. Refer to: Bloodborne Pathogen Post-Exposure Report Form				
	Description of the sharp that was involved in the incident (if applicable). Refer to: Sharps Injury Log				
SBCC District:	Investigate circumstances surrounding the exposure incident. Refer to: Bloodborne Pathogen Exposure Investigation Form				
	If appropriate, make immediately available a confidential medical evaluation and follow-up.				
	Will offer repeat HIV testing to the exposed employee at designated intervals post-exposure. (i.e., 12 weeks and 6 months post exposure.)				
	Follow-up of the exposed employee shall include counseling, medical evaluation of any acute febrile illness that occurs within 12 weeks post-exposure.				
	Will use Post-Exposure Report Form/Checklist to verify that all steps in the post-exposure process have been taken correctly.				
Identified Source Fol	low-up:				
SBCC District:	Will seek to obtain consent of identified source. Refer to: Source Individual Consent Form				
	Obtain identified source for authorization for disclosure. Refer to: Authorization For Disclosure Form.				
	Make medical evaluation and follow-up appointments.				
	If source individual refuses to sign above consent, District to document refusal.				



Sharps Injury Log <u>Please complete a Log for each employee exposure incident involving a sharp</u>

Name:Departm	nent
Name: Departm Address: City:	State:Zip Code
	injury://
Description of the exposure:	
Job classification:	
	□ Faculty/Staff
	□ Student
□ Facilities	□ Other
Department/Location:	
□ Health Services	□ General campus
Classroom	□ Other
Did the exposure incident occur:	
□ During use of sharp	□ While putting sharp into disposal container
□ Disassembling	□ Sharp left, inappropriate place (table, bed, etc)
□ Between steps of a multi-step procedure	□ Other
□ After use and before disposal of sharp	
Body part:	
(check all that apply)	
□ Finger	□ Torso
□ Hand	
Arm	□ Other
□ Face/Head	
Identify sharp involved (if known):	
Injury occurred before or after activation of mechanism	□ Before □ After
Device had protective mechanism	\Box Yes \Box No \Box Don't know
Type:	
Brand:	
Model:	ry protection, do you have an opinion that such a mechanism
could have prevented the injury? \Box Yes \Box No	ry protection, do you have an opinion that such a mechanism
Explain	
~	
Do you have an opinion that any other engineering, administ	trative or work practice control could have prevented the
injury? \Box Yes \Box No	
Explain:	
Signature of injured: Date:	//
Signature of recorder: Date:	//

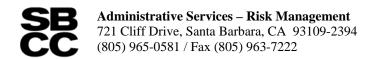


Sharps Injury Log

Date & Time	Name	Dept.	Position	Location of Incident	Type of Injury	Device Brand Name & Type	How Injury Occurred *	Protective Mechanism? (Yes / No)	Occurred Before, During or After Activation of Mechanism?	Employee Opinion**

* Include: 1. Procedure being performed 2. Body part involved in exposure

** Include: (If sharp had no protection) 1. Employee opinion as to whether protection would have prevented injury 2. Whether any other engineering, administrative, or work practice control could have prevented the injury.



SOURCE INDIVIDUAL CONSENT FORM

I,	, have been identified as the source of blood or bodily
Name	
fluid involved in an occupation	al exposure incident at
_	(Place of exposure)
on	Pursuant to Cal/OSHA regulations governing
bloodborne pathogens, and the	Exposure Control Plan enacted by Santa Barbara City College,
I have been requested to conser	nt to the testing of my blood to detect the presence of antibodies to
the Human Immunodeficiency	Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus
(HCV).	

Accordingly:

_____ I refuse to grant my consent for such testing.

_____ I grant my consent for the testing of my blood and/or bodily fluid in order to ascertain whether the HIV, HBV or HCV is present. My consent is hereby given voluntarily of my own free will. My consent has not been obtained through duress, coercion or pressure.

Dated: _____

Signature

Printed Name

Parent/Guardian's Signature if Minor

Printed Parent/Guardian's Name if Minor



Bloodborne Pathogen Vaccine Request Form

Name _____

Department _____

Job Title _____

Please attach current job description.

Specific job duties that you feel put you at risk of exposure to Hepatitis B and other bloodborne pathogens:

Identify situations that put you at risk of exposure to Hepatitis B and other bloodborne pathogens:

Employee signature		Date
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Committee Review date	
Recommendations:	
Signature of Business Services Manager	_ Date