

**REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS**

*(This is not a Claim Form)*

Name  
Last First M.I. Soc. Sec. No. \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Phone No. \_\_\_\_\_  
1) \_\_\_\_\_  
2) Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
3) Employers' or Firms' Full Name \_\_\_\_\_  
4) Employers' or Firms' Address \_\_\_\_\_  
Phone No. \_\_\_\_\_  
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 fluids were you exposed to?  
Blood \_\_\_\_\_ Vaginal fluid \_\_\_\_\_ Any other fluids containing blood \_\_\_\_\_  
Semen \_\_\_\_\_ Surgical fluid \_\_\_\_\_ (Describe) \_\_\_\_\_

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 fluids take place through your a) skin \_\_\_\_\_  
Or 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 TEN (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 EXPOSURE.
- D. YOU MUST FILE A WORKERS' COMP 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: \_\_\_\_\_

Employer: KEEP ORIGINAL (Notify Carrier) Employee: KEEP COPY