Health Care Professional's Written Opinion for Post-Exposure Evaluation

Employee's Name: _____

Date of Incident: _____

Date of Evaluation: _____

Health Professional's Address: _____

_____

Health Professional's Telephone: _____

____ The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.

____ The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

____ Hepatitis B vaccination **is**____ **is not**____ indicated.

_____
Health Care Professional's Name

_____ _____
Health Care Professional's Signature Date

Return this form to the employer and provide a copy to the employee within 15 days. Please label the outside of the envelope "Confidential."

Employer's Name _____

Employer's Address: _____

_____

Confidential Fax: _____