

DEPARTMENT OF THE ARMY  
BROOKE ARMY MEDICAL CENTER  
Fort Sam Houston, Texas 78234

BAMC MEMORANDUM  
No. 40-135

7 May 2003

Medical Services  
BLOOD AND BODY FLUID EXPOSURE MANAGEMENT

1. PURPOSE. To define standards, procedures, and treatment modality for healthcare workers who have accidental percutaneous (needlestick), ocular, or mucous membrane exposure to blood or other body fluids.

2. REFERENCES.

- a. AR 40-5, Preventive Medicine, October 1990.
- b. Centers for Disease Control and Prevention (CDC). *Protection Against Viral Hepatitis*, Morbidity and Mortality Weekly Report, February 9, 1990, Volume 39, Number RR-2.
- c. Centers for Disease Control and Prevention. *Updated Public Health Service Guidelines for the Management of Occupational Exposures to HBC, HCV, HIV and Recommendations for Postexposure Prophylaxis*, Morbidity and Mortality Weekly Reports (MMWR), June 29, 2001, Volume 50 (RR11), Pages 1–52.
- d. Occupational Safety and Health Administration (OSHA). *Occupational Exposure to Bloodborne Pathogens*, Federal Register, 6 December 1991, Volume 56, Number 235.
- e. Centers for Disease Control and Prevention. *Recommendations for Follow-up of Healthcare Workers After Occupational Exposure to Hepatitis C Virus*, Morbidity and Mortality Weekly Report, 4 July 1997, Pages 603-606.
- f. Centers for Disease Control and Prevention. *Preventing Needlestick Injuries in Healthcare Settings*. National Institute for Occupational Safety and Health (NIOSH) Alert, November 1999.
- g. Occupational Safety and Health Administration (OSHA). *Prevention of Needlestick and Sharps Injuries (Long Term Actions)*, 22 November 1999.
- h. Needlestick Safety and Prevention Act (H.R. 5178), Public Law 106-430.

3. GENERAL.

a. This policy is applicable to all permanent party and transient uniformed, civil service, and contract BAMC personnel.

\*This memorandum supersedes BAMC Memorandum 40-135, 24 March 1998.

b. The principal diseases of concern for healthcare workers (HCW) through accidental percutaneous, ocular, or mucous membrane exposure to infectious blood or other potentially infectious material (OPIM) are hepatitis B (HBV), human immunodeficiency virus (HIV), and hepatitis C (HCV). This memorandum focuses on protection from these pathogens. While other diseases (e.g., influenza, tuberculosis) may present risk to HCW through these and other routes of exposure (aerosol, oral, etc.), the procedures in this memorandum will also assist in safeguarding against their transmission by accidental percutaneous, ocular, or mucous membrane exposure. Special cases of concern (unusual pathogens, isolation procedure breakdowns) should be brought to the attention of the BAMC infection control committee.

c. Prospective studies of HCWs have estimated the average risk for HIV transmission after percutaneous exposure to HIV-infected blood is approximately 0.3% and after a mucous membrane exposure is 0.09%. The average risk for HBV transmission ranges from 6-30% after a single needlestick exposure to an HBV-infected patient. The average risk for HCV transmission ranges from 0-7% per injury, resulting in a rate of 1.8%.

d. Episodes of HIV transmission after skin exposure have been documented; the average risk for transmission by this route has not been precisely quantified because no HCWs enrolled in the prospective studies have seroconverted after an isolated skin exposure. The risk for transmission is estimated to be less than the risk for mucous membrane exposure.

#### 4. DEFINITIONS.

a. Exposure. Defined as percutaneous injury (e.g., a needlestick or cut with a sharp object), contact of mucous membrane or nonintact skin (e.g., when the exposed skin is chapped, abraded, or afflicted with dermatitis), or contact with intact skin when the duration of contact is prolonged (i.e., several minutes or more) or involves an extensive area, with blood, tissue, or other body fluids. The **Exposed** Person is the one who has been stuck by the needle or cut by the object.

b. Other potentially infectious materials (OPIM):

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult to impossible to differentiate between body fluids.

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(3) HIV containing cell or tissue cultures, organ cultures, and HIV or Hepatitis B containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or hepatitis B.

(4) Urine is not considered to be potentially infections for transmissible viruses unless contaminated with blood.

c. Source or **Source Patient**. Individual who is point of origin of blood and/or OPIM.

d. Postexposure Prophylaxis (PEP). The provision/administration of antiretroviral drugs, vaccine, or immune globulin after an exposure to infectious or potentially infectious blood or OPIM.

--5. RESPONSIBILITIES.

a. Individuals experiencing a blood or body fluid exposure incident will--

(1) Immediately initiate first aid by thoroughly washing the exposed area with soap and water, and irrigating exposed mucous membranes with water.

(2) Report exposure to blood/OPIM immediately to supervisor. The supervisor will initiate the Blood and Body Fluid Exposure Checklist (Appendix A). Civilian employees who decline evaluation by health care personnel after being counseled on the risks and benefits of undergoing or declining such evaluation, will sign the Hepatitis B Immunization Consent or Decline Form (Appendix C).

(3) Brooke Army Medical Center (BAMC), Dental Activity, and Institute of Surgical Research (ISR) personnel should present to the Department of Emergency Medicine (ED) with BAMC Form 889, Mishap/Injury Report (Appendix D), and the Report of Exposure to Blood/Body Fluid (Appendix B), if possible. *If urgent HIV Post Exposure Prophylaxis(PEP) with antiretroviral drugs is likely to be indicated, report immediately to ED.*

(4) Report to the ED and identify themselves to the charge nurse as soon as possible. If the source of exposure is known or suspected to be HIV positive, individual should report immediately to ED.

b. The healthcare worker's (HCWs) immediate supervisor will--

(1) Ensure steps 5a(1) through 5a(4) above are completed. If the HCW refuses treatment, the HCW must sign the Hepatitis B Immunization Consent or Decline Form (Appendix C), witnessed by the supervisor; then forward to Department of Preventive Medicine (MCHE-DHO).

(2) Assist exposed personnel in completing the necessary forms before sending to ED [i.e., BAMC Form 889, Mishap/Injury Report (Appendix D), CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (Appendix E), etc.]. In emergency situations, the supervisor should contact ED as soon as possible with the pertinent information.

c. The BAMC Department of Emergency Medicine personnel will--

- (1) Treat injury appropriately.
- (2) Follow protocol as outlined in Appendix A, Section C, steps 1 through 13.
- (3) Follow hepatitis B algorithm (Appendix F) to determine whether HBIG should be administered immediately (source patient is known to be HBV carrier (HBV surface antigen (HBsAg) positive), and HCW is not vaccinated or is known to be a nonresponder to vaccine).
- (4) Administer tetanus booster, as indicated.
- (5) Refer HCW to Department of Preventive Medicine, Occupational Health Section (Extension 295-2437), to be seen on same or next duty day for lab follow-up.
- (6) Place all records (Appendices A-E) in box for pickup by Department of Preventive Medicine personnel.

d. Infectious Disease Service will--

- (1) Provide consultative services to Department of Emergency Medicine and Department of Preventive Medicine. The on-call Infectious Disease fellow will support the emergency department with STAT consultation response as necessary to assist in determining need for HIV postexposure prophylaxis.
- (2) Provide PEP follow-up care and counseling. Asymptomatic employees receiving PEP should be seen every two weeks.

e. Source Patient's Physician/Healthcare Provider will--

- (1) Assist the ED in determining the source patient's infectious status by providing known risk history, ordering source patient laboratory testing, and reviewing the chart as necessary.

f. Department of Preventive Medicine, Occupational Health Section personnel will provide follow-up care for military, civilian and contract and civilian personnel. Follow-up for contract workers will also be provided by Department of Preventive Medicine, Occupational Health Clinic. Any costs associated with these services may be charged back to the contractor.

(1) The protocol for employees exposed to a known HBsAg positive source is--

- (a) Receive hepatitis B vaccine. All civilian HCW personnel hired after January 1997 are required to receive HBV immunization (AR 40-562, paragraph 21.2.) Other employees who have not been immunized will be encouraged to receive the hepatitis B vaccine. The vaccine is required for all Army active duty medical personnel assigned to BAMC. Contract employees are required to be immunized.

(b) Review the ED record to ensure initial lab work was obtained and hepatitis B immune globulins (HBIG) given when appropriate.

(c) Instruct the employee to contact the Occupational Health Clinic (295-2437) within one week. At that time, results of the initial lab tests will be evaluated. When an employee is found to be hepatitis B surface antibody (HBsAb) positive, no further evaluation for hepatitis B is necessary. Any significant finding involving clinical assessment or lab test results will be referred to the Occupational Medicine service or Infectious Disease clinic.

(d) When known, the source individual's test results shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(2) Protocol for employees *exposed to a known HIV positive source*. Provide HIV screening and/or further HIV screening. HIV screening will be repeated at six weeks, and at three and six months. If civilian employees refuse screening, a blood sample may be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status.

(3) Protocol for employees *exposed to an unknown but suspected HIV positive source*. Unknown sources should be treated as "potentially infectious" and affected employee should be medically evaluated and appropriately counseled. Appropriate prophylaxis should be administered after counseling has been completed.

(4) Protocol for employees *exposed to a known hepatitis C positive source*.

(a) Perform baseline and follow-up testing for anti-HCV and alanine aminotransferase.

(b) The enzyme immunoassay for hepatitis C is a very sensitive test. If the source patient has a negative EIA, the healthcare worker does not need to undergo any follow-up testing for HCV infection.

(c) Confirm by supplemental HCV testing all anti-HCV results reported as repeatedly reactive by enzyme immunoassay.

(d) Postexposure prophylaxis with immune globulin or antiretroviral agents (e.g., interferon) is not recommended.

(5) A copy of the healthcare provider's written opinion shall be provided to the employee within 15 days of the completion of the initial evaluation. The healthcare provider's written opinion for post exposure evaluation and follow-up shall be limited to the following information:

(a) That the employee has been informed of the results of the evaluation.

(b) That the employee has been told about any medical conditions resulting from exposure.

(c) The healthcare provider's written opinion for hepatitis B vaccination shall be limited to whether hepatitis B vaccination is indicated for the employee, and if the employee has received such vaccination.

(d) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

APPENDICES

<b>APPENDIX A</b>	<i>BLOOD AND BODY FLUID EXPOSURE CHECKLIST</i>
<b>APPENDIX B</b>	<i>REPORT OF EXPOSURE TO BLOOD OR BODY FLUID</i>
<b>APPENDIX C</b>	<i>HEPATITIS B IMMUNIZATION CONSENT OR DECLINE FORM</i>
<b>APPENDIX D</b>	<i>BAMC FORM 889 – MISHAP/INJURY REPORT</i>
<b>APPENDIX E</b>	<i>OWCP – CA – 1</i>
<b>APPENDIX F</b>	<i>HEPATITIS B POSTEXPOSURE PROPHYLAXIS TABLE</i>
<b>APPENDIX G</b>	<i>HIV POSTEXPOSURE PROPHYLAXIS TABLES</i>
<b>APPENDIX H</b>	<i>IMPLEMENTATION PLAN</i>

**APPENDIX A**

**BLOOD AND BODY FLUID EXPOSURE CHECKLIST**

**A. IMMEDIATELY (at the time of exposure) the health care worker (HCW) will:**

- 1. Initiate first aid (wash exposed skin with soap and water, flush mucous membranes, and/or irrigate eyes with water).
- 2. Report the incident to the immediate supervisor.
- 3. Report to the Emergency Department (ED). Bring completed BAMC Form 889, Mishap/Injury Report Form and information regarding the source patient. If source patient is known or suspected to be HIV positive, report immediately to the ED for evaluation for postexposure prophylaxis (PEP).

**B. The HCW's supervisor will:**

- 1. Ensure STEPS 1 through 3 above are completed. If HCW refuses treatment, have the HCW sign Declination of Treatment Statement (Appendix B), witness and forward to Department of Preventive Medicine, Occupational Health Section (MCHE-DHO).
- 2. Send source patient information with injured HCW to **OR** call the Emergency Department (**916-3693**) as soon as practical (ASAP) with the above information.
- 3. Complete BMC FORM 889, MISHAP/INJURY REPORT to send with HCW or FAX (6-2297) or tube to ED.

**C. The Emergency Department (ED) will--**

- 1. Triage HCW into emergency category if source is known or suspected to be HIV positive.
- 2. Ensure that first aid was or is performed adequately.
- 3. Obtain information from CHCS and the source patient's physician regarding source patient HIV, hepatitis B, and C status, and risk of these infections if status is unknown.
- 4. Instruct the source patient's physician to order source patient labs if HIV, HBV, or HCV status is unknown. (CHCS lab panel=**NEEDLESTICK SOURCE**)
- 5. Use exposure type and HIV infection status to determine recommendation of HIV PEP (See Appendix G). IMMEDIATELY consult Infectious Disease fellow on-call if questions arise regarding PEP.

- 6. If HIV PEP is indicated, 1) offer immediate pregnancy testing for all women of childbearing age not known to be pregnant, and 2) initiate PEP immediately. INITIATION OF PEP SHOULD NOT BE DELAYED. THE OBJECTIVE DESIRED IS TO BEGIN INDICATED HIV PEP WITHIN ONE HOUR FROM EXPOSURE. HOWEVER, INDICATED SHOULD STILL BE INITIATED EVEN WHEN A DELAY HAS OCCURRED. This can be accomplished through the ER paxis or STAT through the inpatient pharmacy. Provide exposed HCW enough antiretroviral medication to last until first follow up in Infectious Disease clinic (usually limited to 3 day supply).
- 7. IMMEDIATELY contact the Infectious Disease fellow on-call to arrange follow up of ALL exposed HCW started on HIV PEP.
- 8. Initiate the completion of APPENDIX B, Report of Exposure to Blood/Body Fluid.
- 9. Obtain blood from the exposed HCW for testing. (CHCS lab panel=**NEEDLESTICK EXPOSED-HCW**) If antiretroviral medications are indicated, also draw a CBC, LFTs and Chem-7.
- 10. Follow the hepatitis B algorithm (Appendix F) to determine whether HBIG should be administered immediately (source patient is known to be HBV carrier, and the HCW is not vaccinated or is known to be a nonresponder to vaccine).
- 11. Administer tetanus toxoid *if over five years since last vaccination.*
- 12. Refer HCW to Department of Preventive Medicine, Occupational Health Section (295-2437) to be seen same or next duty day for lab follow-up.
- 13. Place all completed medical records (Blood and Body Fluid Exposure Packet) in box outside ED for follow-up.

NOTES:

CHCS LABORATORY PANEL	TUBE	INCLUDES
NEEDLESTICK SOURCE	marble red top	rapid HIV, HB <sub>s</sub> Ag, HCV Ab
NEEDLESTICK EXPOSED-HCW	marble red top	HIV, HB <sub>s</sub> Ab, HCV Ab

D. The **BAMC Occupational Health Section (OH)** will--

- 1. Ensure documentation of the route and circumstances of the incident, including the source individual, unless identification is prohibited by state or local laws or deemed not feasible.
- 2. If testing of source patient was, for some reason, not done at the time of the incident, arrange to test the source individual blood as soon as feasible and with their consent to determine HBV/HCV status. Source individuals known to be HIV infected need not be retested. The exposed employee shall be informed of the source individual's test results and of the applicable laws and regulations concerning disclosure of the identity and status of the source patient.

- 3. If testing of HCW was, for some reason, not done at the time of the injury, collect and test the potentially exposed employee's blood, with consent, as soon as feasible. If the employee consents to blood baseline but not to HIV serologic testing, the sample shall be preserved for at least 90 days, and tested as soon as feasible if the employee subsequently consents to HIV testing
- 4. Provide the exposed employee with confidential counseling, treatment, and evaluation of reported illnesses.
- 5. Provide the health care professional who is treating or evaluating the employee with a description of the employee's duties, the circumstances of the exposure, and all relevant medical records.
- 6. Provide the employee a written opinion from the health care provider within 15 days of the evaluation. The opinion shall address whether HBV vaccination is recommended and whether it has been administered to the employee. The remainder of the opinion is limited to a statement that the employee has been informed of the results of the evaluation, and that the employee has been told about any medical conditions resulting from the exposure. All other findings shall remain confidential and not be included in the report.

# BLOOD AND BODY FLUID EXPOSURE ALGORITHM

This algorithm is designed to guide the evaluation of blood and body fluid exposures and prevent transmission of infectious diseases. To effectively prevent transmission of HIV from High Risk sources, antiretroviral therapy must be started as soon as possible after the exposure. Our goal is to complete the evaluation and initiate therapy in less than 1 hour when therapy is indicated. Only exposures from High Risk sources require immediate consultation with an Infectious Disease (pager 513-2717 or 916-4355/5554). The definition of a High Risk source is outlined below.

**EXPOSED PERSON (EP) sustains  
CONTAMINATED FLUID EXPOSURE  
or  
NEEDLESTICK/SHARPS INJURY (NSI)**

**EXPOSED PERSON (EP)**

1. Wash site of injury with soap and water
2. Report injury to supervisor *immediately*
3. Report to the BAMC ER with appropriate documentation (Form CA-1, CA-16 and BAMC Form 899)
4. MUST see BAMC Occupational Health within 48 hours (DIAL 295-2437 for an appointment.)

**EP SUPERVISOR**

1. Prepare documentation
2. Send EP to BAMC ER

**EMERGENCY ROOM**

1. Clean wound; give tetanus prophylaxis as needed.
2. Determine source patient's HIV, HBV, and HCV by review of CHCS, medical records, and/or by contacting source patient's physician. Instruct source patient's physician to order HIV, HCV Ab, and HBsAg (HBV surface antigen) if status is unknown [CHCS LAB PANEL = **NEEDLESTICK SOURCE**].
3. If source is at High Risk or known positive for HIV, consult Infectious Disease on-call *IMMEDIATELY*
4. Initiate HIV and HBV postexposure prophylaxis (PEP) as indicated.
5. Order the following three (3) test on the EP: HIV, HCV Ab, HBsAb (HBV surface antibody) [CHCS LAB PANEL = **NEEDLESTICK EXPOSED-HCW**].
6. Refer EP (*WRITTEN CONSULT*) to Occupational Health (OH) to be seen within 48 hrs. FAX info to 295-2456.

**ID CLINIC**

*If source patient is a "High Risk Source" (See definitions)*

1. Provides counseling and recommends course of treatment.
2. Provides follow up care for ALL EP started on HIV postexposure prophylaxis
3. Consult to OH for follow-up.

**DEFINITIONS:**

A "High Risk Source" is a source with a history of any of the following:

1. HIV Infection
2. IV Drug Abuse
3. Multiple Sexually Transmitted Disease
4. Multiple Sex Partners

(A "High Risk Exposure" is one involving a large, hollow-bore needle with visible blood.)

**OCCUPATIONAL HEALTH**

1. See injured EP within 48 hours and assess risk for HIV, HBV, and HCV.
2. Review treatment in ER.
3. Follow-up on labs ordered on EP and source patient.
4. Maintain database on injury; submit reports to Infection Control, BAMC Safety, and Environment of Care (EOC)
5. Follow-up EP per OH Follow-up Algorithm.

### APPENDIX B

REPORT OF EXPOSURE TO BLOOD/BODY FLUID			
For use of this form, see BAMC Memo 40-135 or BAMC Memo 40-169; the proponent is Dept of Prev Med			
This form is to be completed by the injured health care worker (HCW) in conjunction with his/her supervisor, provided to the ED to assist with their evaluation and then forwarded to Department of Preventive Medicine, Occupational Health Section (MCHE-DHO) for final review and disposition.			
<b>PERSON EXPOSED</b>		RANK	TITLE
NAME		POSITION	
<b>DATE/TIME OF EXPOSURE</b>		<b>WHERE DID EXPOSURE OCCUR</b>	<b>DATE/TIME OF THIS REPORT</b>
DATE	TIME		DATE
			TIME
<b>ACCIDENT FIRST REPORTED TO</b>		POSITION	TITLE
NAME			
<b>DESCRIBE THE CIRCUMSTANCES SURROUNDING THE EXPOSURE</b>			
<b>SOURCE PATIENT INFORMATION</b>		DATE OF BIRTH	LOCATION
NAME		LAST 4 SSN	
<b>DETAILS OF EXPOSURE</b>			
1. Is the source patient known to be infected with HIV, hepatitis B or C, or suspected to be at risk for those infections? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Injury was: <input type="checkbox"/> Superficial/Topical <input type="checkbox"/> Moderate <input type="checkbox"/> Severe/Deep			
3. If a sharp injury occurred, was the item contaminated with blood? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Did the injury result in puncture to the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. If puncture occurred, did the injury occur through gloves or protective barrier? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Was there visible blood produced at the site of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Type of body fluid involved (please check any and all that apply):			
<input type="checkbox"/> Blood <input type="checkbox"/> Pericardial Fluid <input type="checkbox"/> Body Fluid with visible Blood <input type="checkbox"/> Urine <input type="checkbox"/> Peritoneal Fluid <input type="checkbox"/> Cerebrospinal Fluid <input type="checkbox"/> Saliva <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Gastric Contents or Vomitus <input type="checkbox"/> Sputum <input type="checkbox"/> Synovial Fluid <input type="checkbox"/> Endotracheal Secretions <input type="checkbox"/> Open Sores <input type="checkbox"/> Seminal Fluid <input type="checkbox"/> Vaginal Secretions <input type="checkbox"/> Feces <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other (describe): _____			
8. Type of instrument or device that caused injury (please check all that apply):			
<input type="checkbox"/> Needle, Open Bore <input type="checkbox"/> Needle, Closed Bore (E.G., Suture) <input type="checkbox"/> Scalpel or Blade <input type="checkbox"/> Scissors <input type="checkbox"/> Lancet <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Trocar <input type="checkbox"/> Bone Cutter <input type="checkbox"/> Bone Chips <input type="checkbox"/> Safety Designed Device <input type="checkbox"/> Splash Injury (describe): _____ <input type="checkbox"/> Other (describe): _____ <input type="checkbox"/> Unknown			
9. Activity leading to exposure:			
<input type="checkbox"/> Drawing Blood <input type="checkbox"/> Starting IV, Venous or Arterial Line <input type="checkbox"/> Controlling Bleeding <input type="checkbox"/> Giving Injection <input type="checkbox"/> Handling Sharps Disposal Container <input type="checkbox"/> Handling Laboratory Specimens <input type="checkbox"/> Recapping Needle <input type="checkbox"/> Discarding Needle or Sharp Object <input type="checkbox"/> Handling Urinary Catheter <input type="checkbox"/> Handling IV Lines <input type="checkbox"/> Item Protruding Through Trash or Linen <input type="checkbox"/> Surgical/Invasive Procedure <input type="checkbox"/> Handling N-G Tube <input type="checkbox"/> Disassembling Device or Equipment <input type="checkbox"/> Cleaning Blood/Body Fluid Spill <input type="checkbox"/> Other (describe): _____			

SAMPLE

APPENDIX C

<b>MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA</b>				
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.				
<b>REPORT TITLE</b> HEPATITIS B IMMUNIZATION (CONSENT OR DECLINE) <small>For use of this form, see BAMC Memo 40-135 or 40-169; the proponent is Dept of Prev Med</small>			<b>OTSG APPROVED (Date)</b> MFR Aprr 18 Mar 03	
<b>EMPLOYEE'S NAME (Please print)</b>			<b>SSN</b>	
<b>DEPARTMENT WORKSITE</b>		<b>BUILDING WORKSITE</b>		<b>ROOM OR AREA</b>
<b>CONSENT TO HEPATITIS B VACCINATION</b>				
I have read the information about hepatitis B and the hepatitis B vaccine. I have had an opportunity to ask questions of a qualified nurse or physician and understand the benefits and risks of hepatitis B vaccination. I understand that I must have 3 doses of the vaccine to obtain immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience side effects from the vaccine.				
<b>SIGNATURE OF EMPLOYEE</b>			<b>DATE SIGNED</b>	
If you will not be at BAMC for the third dose, please let us know your address and telephone number so we can notify you.				
<b>ADDRESS</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>PHONE NUMBER</b>				
<b>DECLINE OF HEPATITIS B VACCINATION</b>				
I UNDERSTAND that due to my occupational exposure to blood or other potentially infectious materials 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 hepatitis B vaccination 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 hepatitis B vaccine, I can receive the vaccination series at no charge to me.				
<b>SIGNATURE OF EMPLOYEE</b>			<b>DATE SIGNED</b>	
A copy of this form will be placed in your medical record. Per BAMC Memo 40-135, Occupational Health Services will notify your immediate supervisor if you choose to decline the Hepatitis B vaccination.				
<b>PREPARED BY (Signature &amp; Title)</b>			<b>DEPARTMENT/SERVICE/CLINIC</b>	
			<b>DATE</b>	
<b>PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)</b>			<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input checked="" type="checkbox"/> OTHER (Specify) (Consent/Decline) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT	
<b>DA FORM 4700</b> <small>1 MAY 78</small>		REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.		<b>BAMC OP 919, APR 2003</b> <small>BFF V1.00</small>

SAMPLE

**APPENDIX D**

<b>INCIDENT/INJURY/NEAR MISS REPORT</b>										DATE PREPARED
For use of this form, see BAMC Reg 385-1; the proponent is Safety Office										
DATA REQUIRED BY THE PRIVACY ACT OF 1974										
<b>Authority</b> 5 USC, Section 7902; Pub L. 91-596, Section 18, Occupational Safety and Health Act of 1970 and Section 2, Executive Order 11087 Occupational Safety and Health Programs for Federal Employees. <b>Principal Purpose</b> Information will be used to develop accident prevention countermeasures. <b>Routine Uses</b> None. <b>Disclosure</b> Disclosure of this information is voluntary. However, failure to provide information requested would delay report and could result in repeat injury/nonexistent accident prevention countermeasures.										
SECTION I - DATA CONCERNING INJURED PERSON/INCIDENT/NEAR MISS										
1. NAME OF INJURED PERSON (Last, First, MI)			2. SSN		3. AGE	4. SEX	5. DUTY STATUS (Time of injury)			
							<input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty			
6. GRADE/RANK		7. MOS/JOB SERIES		8a. ORGANIZATION (Div/Svc/Clinic)			8b. DATE JOINED ORGANIZATION		9. DUTY PHONE NUMBER	
10. TIME AND DATE OF MISHAP		11. DATE REPORTED		12. EXACT LOCATION WHERE INJURY OCCURRED (Bldg, ward, clinic, room, etc.)						
a. HOUR		b. DATE								
13. OCCUPATION OR DUTY WHEN INJURY OCCURRED				14. ACTION BEING PERFORMED AT TIME OF ACCIDENT						
15a. NATURE OF INJURY					15b. BODY PART(S) INVOLVED					
<input type="checkbox"/> Burns <input type="checkbox"/> Bruise <input type="checkbox"/> Crushed <input type="checkbox"/> Cut <input type="checkbox"/> Dermatitis <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Hema <input type="checkbox"/> Infection <input type="checkbox"/> Pull <input type="checkbox"/> Puncture <input type="checkbox"/> Respiratory Irritation <input type="checkbox"/> Scrape <input type="checkbox"/> Sprain <input type="checkbox"/> Spasm <input type="checkbox"/> Strain <input type="checkbox"/> String <input type="checkbox"/> Toxic Exposure <input type="checkbox"/> Needle Stick/Sharps (Section II, mandatory) <input type="checkbox"/> OTHER: _____					<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> N/A <input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Knee <input type="checkbox"/> Leg (Upper) <input type="checkbox"/> Leg (Lower) <input type="checkbox"/> Neck <input type="checkbox"/> Side <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Wrist <input type="checkbox"/> OTHER: _____					
16a. TREATMENT RECEIVED		16b. LOCATION OF TREATMENT RECEIVED (ER, on-site, etc.)			17. NUMBER OF ACTUAL LOST WORK DAYS		18. ESTIMATED DAMAGES			
					a. HOSPITAL		b. QUARTERS		c. %    \$	
19. DESCRIBE HOW INJURY/INCIDENT/NEAR MISS OCCURRED										
<div style="font-size: 4em; opacity: 0.5; pointer-events: none;">SAMPLE</div>										
SECTION II - NEEDLE STICK/SHARPS										
1. EQUIPMENT/DEVICE INVOLVED					2. DEVICE TYPE					
					<input type="checkbox"/> Safety <input type="checkbox"/> Conventional					
3. DESCRIBE INCIDENT (For needle stick: Indicate device [type and brand] used and procedure being performed)										
SECTION III - SUPERVISOR'S COMMENTS AND/OR CORRECTIVE ACTIONS										
1a. SUPERVISOR'S NAME			1b. GRADE/RANK		1c. DUTY PHONE NUMBER		2. SUPERVISOR PRESENT AT TIME OF INCIDENT/INJURY			
							<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but did not observe			
3a. DATE GENERAL SAFETY TRAINING COMPLETED		3b. DATE JOB SPECIFIC SAFETY TRAINING COMPLETED		4. PERSONAL PROTECTIVE EQUIPMENT						
				<input type="checkbox"/> Required <input type="checkbox"/> Available <input type="checkbox"/> Used <input type="checkbox"/> Failed (How) _____ <input type="checkbox"/> Not Used (Why) _____						
5. PROBABLE CAUSE										
6. ACTION(S) TAKEN BY REPORTING ACTIVITY AS A RESULT OF THE INCIDENT										
7a. SUPERVISOR'S SIGNATURE					7b. DATE			FOR CIVILIAN INJURIES A COPY OF CA FORM 1 AND 16 MUST BE ATTACHED		

APPENDIX E

**Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation**

**U.S. Department of Labor**  
 Employment Standards Administration  
 Office of Workers' Compensation Programs



**Employees:** Please complete all boxes 1 - 15 below. Do not complete shaded areas.  
**Witness:** Complete bottom section 16.  
**Employing Agency (Supervisor or Compensation Specialist):** Complete shaded boxes a, b, and c.

<b>Employee Data</b>			
1. Name of employee (Last, First, Middle)			2. Social Security Number
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone ( )	6. Grade as of date of injury Level Step
7. Employee's home mailing address (include city, state, and zip code)			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other

<b>Description of Injury</b>			
9. Place where injury occurred (e.g. 2nd floor, Mail Post Office Bldg., 12th & Pine)			
10. Date injury occurred Mo. Day Yr.	Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation

13. Cause of injury (Describe what happened and why)

---

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code	b. Type code	c. Source Code
OWCP Use - NOI Code		

<b>Employee Signature</b>
15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injury myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584. <input type="checkbox"/> b. Sick and/or Annual Leave I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf \_\_\_\_\_ Date \_\_\_\_\_

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

**Have your supervisor complete the receipt attached to this form and return it to you for your records.**

<b>Witness Statement</b>
16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness \_\_\_\_\_ Signature of witness \_\_\_\_\_ Date signed \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Official Supervisor's Report: Please complete information requested below:**

**Supervisor's Report**

17. Agency name and address of reporting office (Include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
	Zip Code

18. Employee's duty station (Street address and zip code)	Zip Code
---	----------

19. Regular work hours From: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
---	---

21. Date of Injury Mo. Day Yr. : : : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	22. Date Notice Received Mo. Day Yr. : : :	23. Date stopped work Mo. Day Yr. : : : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
---	---	--

24. Date pay stopped Mo. Day Yr. : : :	25. Date 45 day period began Mo. Day Yr. : : :	26. Date returned to work Mo. Day Yr. : : : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
---	---	--

27. Was employee injured in performance of duty?  Yes.  No (If "No," explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?  Yes (If "Yes," explain).  No

29. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 31.)	30. Name and address of third party (include city, state, and zip code)
---	---

31. Name and address of physician first providing medical care (include city, state, zip code)	32. First date medical care received Mo. Day Yr. : : :
--	---

33. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness?  Yes  No (If "No," explain)

35. If the employing agency controverts continuation of pay, state the reason in detail.	36. Pay rate when employee stopped work \$ _____ Per _____
--	---

**Signature of Supervisor and Filing Instructions**

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's Title \_\_\_\_\_ Office phone \_\_\_\_\_

38. Filing instructions

<input type="checkbox"/>	No lost time and no medical expense; Place this form in employee's medical folder (SF-66-D)
<input type="checkbox"/>	No lost time, medical expense incurred or expected; forward this form to OWCP
<input type="checkbox"/>	Lost time covered by leave, LWOP, or COP; forward this form to OWCP
<input type="checkbox"/>	First Aid injury

APPENDIX F

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

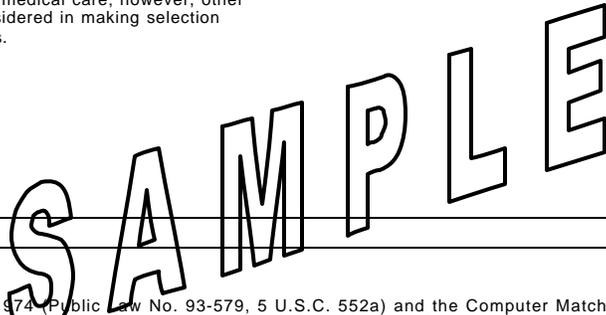
- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)
(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.
(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.
(4) Vocational rehabilitation and related services where necessary.
(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

- (1) The employing agency receives medical information from the attending physician to the effect that disability has terminated;
(2) The OWCP advises that pay should be terminated; or
(3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.



Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by (Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

TABLE 3. Recommended postexposure prophylaxis for exposure to hepatitis B virus

Vaccination and antibody response status of exposed workers*	Treatment		
	Source HBsAg <sup>†</sup> positive	Source HBsAg <sup>†</sup> negative	Source unknown or not available for testing
Unvaccinated	HBIG <sup>‡</sup> x 1 and initiate HB vaccine series <sup>†</sup>	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated			
Known responder**	No treatment	No treatment	No treatment
Known nonresponder <sup>††</sup>	HBIG x 1 and initiate revaccination or HBIG x 2 <sup>‡‡</sup>	No treatment	If known high risk source, treat as if source were HBsAg positive
Antibody response unknown	Test exposed person for anti-HBs <sup>§§</sup> 1. If adequate,** no treatment is necessary 2. If inadequate, <sup>††</sup> administer HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti-HBs 1. If adequate, <sup>§</sup> no treatment is necessary 2. If inadequate, <sup>§</sup> administer vaccine booster and recheck titer in 1–2 months

\* Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis.

<sup>†</sup> Hepatitis B surface antigen.

<sup>‡</sup> Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly.

<sup>§</sup> Hepatitis B vaccine.

\*\* A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs  $\geq 10$  mIU/mL).

<sup>††</sup> A nonresponder is a person with inadequate response to vaccination (i.e., serum anti-HBs  $< 10$  mIU/mL).

<sup>‡‡</sup> The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

<sup>§§</sup> Antibody to HBsAg.

## APPENDIX G

TABLE 4. Recommended HIV post exposure prophylaxis for percutaneous injuries

Exposure type	Infection status of source				
	HIV-Positive Class 1*	HIV-Positive Class 2*	Source of unknown HIV status <sup>†</sup>	Unknown source <sup>‡</sup>	HIV-Negative
More severe <sup>†</sup>	Recommend expanded 3-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors <sup>††</sup>	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted
Less severe <sup>†</sup>	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors <sup>††</sup>	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted

\* HIV-Positive, Class 1 — asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL). HIV-Positive, Class 2 — symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of postexposure prophylaxis (PEP) should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

<sup>†</sup> Source of unknown HIV status (e.g., deceased source person with no samples available for HIV testing).

<sup>‡</sup> Unknown source (e.g., a needle from a sharps disposal container).

<sup>††</sup> Less severe (e.g., solid needle and superficial injury).

\*\* The designation “consider PEP” indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

<sup>†††</sup> If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.

<sup>††††</sup> More severe (e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient’s artery or vein).

**TABLE 5. Recommended HIV postexposure prophylaxis for mucous membrane exposures and no intact skin\* exposures**

Exposure type	Infection status of source				
	HIV-Positive Class 1†	HIV-Positive Class 2†	Source of unknown HIV status‡	Unknown source‡	HIV-Negative
Small volume**	Consider basic 2-drug PEP††	Recommend basic 2-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP†† for source with HIV risk factors‡‡	Generally, no PEP warranted; however, consider basic 2-drug PEP†† in settings where exposure to HIV-infected persons is likely	No PEP warranted
Large volume††	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP†† for source with HIV risk factors‡‡	Generally, no PEP warranted; however, consider basic 2-drug PEP†† in settings where exposure to HIV-infected persons is likely	No PEP warranted

\* For skin exposures, follow-up is indicated only if there is evidence of compromised skin integrity (e.g., dermatitis, abrasion, or open wound).

† HIV-Positive, Class 1 — asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL). HIV-Positive, Class 2 — symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Irritation of postexposure prophylaxis (PEP) should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

‡ Source of unknown HIV status (e.g., deceased source person with no samples available for HIV testing).

† Unknown source (e.g., splash from inappropriately disposed blood).

\*\* Small volume (i.e., a few drops).

†† The designation, “consider PEP,” indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

‡‡ If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.

††† Large volume (i.e., major blood splash).

## **APPENDIX H**

### **IMPLEMENTATION PLAN**

1. **Plan for Implementation.** This BAMC memo describes standards, procedures, and treatment modalities for BAMC healthcare workers who have accidental percutaneous (needlestick), ocular, or mucous membrane exposure to blood or other body fluids. The memo will be added to the BAMC Intranet as an updated memo.
2. **Resources Necessary.** BAMC will maintain an adequate supply of post-exposure prophylaxis (PEP).
3. **Audit Plan.** Implementation of this policy will require a multidisciplinary team to include, but not limited to, Occupational Medicine, Infection Control, Infectious Disease, Emergency Department and Safety. All exposures to blood and/or body fluids must be reported to the supervisor. Medical treatment will be administered as outlined in APPENDIX A – Blood and Body Fluid Exposure Algorithm. Follow-up will be maintained by Occupational Health. Referrals to other clinics will be made as necessary. Quarterly summaries will be prepared by Occupational Health and submitted through the Infection Control Functional Management Team (ICFMT) and the Environment of Care Functional Management Team (EOCFMT). An annual program audit will be conducted to identify trends and performance improvement initiatives..
4. **Training.** Department of Preventive Medicine, Occupational Medicine Service will provide department-specific training episodes as required. In addition, Occupational Medicine will provide patient training and education. Healthcare worker general training and education will be monitored through SYNQUEST and supplemented by on-site work area audits to determine level of compliance. Staff compliance with HIPPA directives is required.

The proponents for this memorandum are the Infection Control (IC) Functional Management Team (FMT) and Environment of Care (EOC) Functional Management Team. Department of Preventive Medicine, Occupational Medicine Section serves as technical advisor. Users are invited to send comments and suggestions for improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Brooke Army Medical Center, ATTN: MCHE-DHO, Fort Sam Houston, Texas 78234-6200.

FOR THE COMMANDER:

OFFICIAL:

STEPHEN L. MARKELZ  
Colonel, MS  
Deputy Commander for Administration

ULMONT C. NANTON, JR.  
Lieutenant Colonel, MS  
Chief, Information Management Division