

\*required for saving

\*\*required for completion

^required for exposure management

^Facility ID # : \_\_\_\_\_

^Survey Year: \_\_\_\_\_

^1. Which of the following best describes your occupation/work area?(check one):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Surgical Medical Staff Services | <input type="checkbox"/> Technician                    | <input type="checkbox"/> Housekeeping/Laundry |
| <input type="checkbox"/> Non-Surgical Medical Staff      | <input type="checkbox"/> Clerical/Administrative Staff | <input type="checkbox"/> Other Staff          |
| <input type="checkbox"/> Dental Staff                    | <input type="checkbox"/> Transport/Service             | <input type="checkbox"/> Security             |
| <input type="checkbox"/> Phlebotomist/IV team            | <input type="checkbox"/> Central Supply Staff          | <input type="checkbox"/> Medical Student      |
| <input type="checkbox"/> Nursing staff                   | <input type="checkbox"/> Maintenance/engineering staff | <input type="checkbox"/> Other Student        |

^2. In the past 12 months, have you been injured by a sharp object, such as a needle or scalpel, that was previously used on a patient (contaminated)?

Yes  No (If yes, complete 2. a. and b. below. If no, go to question 3.)

a. If yes, how many contaminated sharp object injuries did you sustain during in this time period? \_\_\_\_\_

b. For how many of these exposures did you complete/submit a blood/body fluid exposure report? \_\_\_\_\_

^3. In the past 12 months did blood or body fluids have direct contact (e.g., through a splash) with your eyes, nose, mouth or skin?

Yes  No (If yes, complete 3. a. and b. below. If no, go to question 4.)

a. If yes, how many blood/body fluid exposures did you sustain during this time period? \_\_\_\_\_

b. For how many of these exposures did you complete/submit a blood/body fluid exposure report? \_\_\_\_\_

\*\*4. If you had sharps object injuries or blood/body fluid exposure you did not report, indicate why: (check all that apply)

- I did not have time to report.
- I did not know the reporting procedure.
- I was concerned about confidentiality.
- I thought I might be blamed or get in trouble for having the exposure.
- I thought the source patient was low risk for HIV and/or hepatitis B or C.
- I thought the type of exposure was low risk for HIV and/or hepatitis B or C.
- I didn't think it was important to report
- Other (please explain) \_\_\_\_\_

**Assurance of Confidentiality:** The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

Custom Fields

Label

|       |                |
|-------|----------------|
| _____ | ____/____/____ |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |

Label

|       |                |
|-------|----------------|
| _____ | ____/____/____ |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |
| _____ | _____          |

Comment