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 et seq., the Information Practices Act, Civil Code section 1798 et seq., 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, its 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                                        Date
# EXPOSURE CONTROL PLAN
## BLOODBORNE PATHOGENS
### DOCUMENTATION OF STAFF EDUCATION

Employee Name ________________________  Job Title ________________________  Department ________________________

Date of Training ________________________  Instructor’s Name ________________________

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>Reviewed (x)</th>
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<tbody>
<tr>
<td>1. Epidemiology/Symptoms/Modes of transmission of HIV / HBV / HCV infections</td>
<td>_____</td>
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<td>2. The Infection Control Program and Manual, including:</td>
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<td>a. Hand washing</td>
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<td>b. Universal Precautions</td>
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<tr>
<td>c. Isolation techniques</td>
<td>_____</td>
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<td>3. The exposure control program</td>
<td>_____</td>
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<td>4. Recognition of activities that can cause exposure</td>
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<td>5. How to prevent/reduce exposure:</td>
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<td>Engineering Controls</td>
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<td>Work Practices</td>
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<td>Personal protective equipment:</td>
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<td>proper use, removal, handling, decontamination, disposal, storage locations, how to select protective equipment</td>
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<td>6. Hepatitis B Vaccine - efficacy, safety, benefits, adverse reactions</td>
<td>_____</td>
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<td>7. Emergencies - persons to contact and actions to take</td>
<td>_____</td>
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<td>8. Exposure incidents - incident report, medical follow-up and counseling at no cost</td>
<td>_____</td>
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<td>9. Labels, signs, and color coding</td>
<td>_____</td>
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<td>10. Infections, spills - cleanup and reporting</td>
<td>_____</td>
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<td>11. Infectious waste handling</td>
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<tr>
<td>12. Handouts given</td>
<td>_____</td>
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</tbody>
</table>

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.

_________________________  _______/_______/_______
Employee Signature  Date

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
# EMPLOYEES ELIGIBLE FOR HEPATITIS-B VACCINATION

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>DEPT.</th>
<th>CONSENT/DECLINE</th>
<th>TRAINING DATE</th>
<th>INOCULATION</th>
<th>COMMENTS</th>
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Hepatitis-A Consent

The MedCenter
Santa Barbara CA
2945 State Street
(805) 682-7411

_______________________________ 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
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 CA
2945 State Street    682-7411
319 N. Milpas Street  965-3011

_________________________ 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 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 CA
2945 State Street  682-7411
319 N. Milpas Street   965-3011

___________________________________ 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 Incident: ______: _______ AM / PM

Name of Exposed Employee: ______________________________________________

Potentially Infectious Materials Involved:

Type: _____________________  Source: ______________________________
      (i.e.: blood or OPIM)      (i.e.: needle, bandages, bleeding wound)

Exposure Circumstances: __________________________________________________

Cause of Incident: ________________________________________________________

Personal Protective Equipment Being Used: _________________________________

Source Individual Identity:       Known ___  Unknown ___
If Known:

1. Consent for blood test obtained  Date: _____/_____/_______
   Blood Collected  Date: _____/_____/_______

2. Consent not obtained  Date: _____/_____/_______
   Verified by: (name) ________________________________________________
   Medical Professional

Comment: __________________________________________________________________

3. Known HIV positive: Yes ___ No ___
   Known Hepatitis-B positive: Yes ___ No ___
   Known Hepatitis-C positive  Yes ___ No

4. Results of Source individual's blood test made available to exposed employee:
   Date: _____/_____/__
BLOODBORNE PATHOGEN POST-EXPOSURE REPORT FORM

Employee Name: ______________________________

Date of Exposure Incident: ______/______/_______    Time of Incident: _____:_____ AM or PM

(Name of Healthcare Provider)

Employee previously vaccinated against HBV infection:        Yes:_____ No: _____ Date: _____/_____/______

Description of employee’s duties during the exposure incident: ________________________________

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 infectious material to: _______________________________

Other: __________________________________________________________________________________________

The circumstances under which exposure occurred are (describe): ______________________________________

Personal protective equipment being used: __________________________________________________________________

The source individual is known: _____Yes _____ No

If known, is known to be infected with HBV ______ HIV _______HCV _______

Request form for blood testing obtained: _____ Yes _____ No

The following remedial action may minimize the likelihood of future exposure: __________________________

__________________________________________________________

Signature of Program Coordinator/Health Services Nurse              Date
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 Follow-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
Please complete a Log for each employee exposure incident involving a sharp

Name: ___________________________________ Department ____________________________
Address: __________________ City: __________________ State: __________ Zip Code ____________
Phone: ( ) _______ - ___________ Date of injury: _______/______ / _______

Description of the exposure:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Job classification:
☐ MD ☐ Nurse ☐ Facilities
☐ Faculty/Staff ☐ Student ☐ Other

Department/Location:
☐ Health Services ☐ Classroom ☐ General campus
☐ 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 ☐ Leg
☐ Arm ☐ Other
☐ Face/Head

Identify sharp involved (if known):
Injury occurred before or after activation of mechanism ☐ Before ☐ After
Device had protective mechanism ☐ Yes ☐ No ☐ Don’t know
Type: __________________________
Brand: _________________________
Model: ________________________

Exposed employee: If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury? ☐ Yes ☐ No
Explain ____________________________________________________________

Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury? ☐ Yes ☐ No
Explain: ____________________________________________________________

Signature of injured: ___________________ Date: _____ / _____ / ______
Signature of recorder: __________________ Date: _____ / _____ / ______
## Sharps Injury Log

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Name</th>
<th>Dept.</th>
<th>Position</th>
<th>Location of Incident</th>
<th>Type of Injury</th>
<th>Device Brand Name &amp; Type</th>
<th>How Injury Occurred *</th>
<th>Protective Mechanism? (Yes / No)</th>
<th>Occurred Before, During or After Activation of Mechanism?</th>
<th>Employee Opinion**</th>
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* 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 fluid involved in an occupational 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 consent 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 ___________

Committee Review date ____________________

Recommendations:

Signature of Business Services Manager ____________________________  Date _______________