Protocol for Employee Reporting of Significant Work Exposure to Bodily Fluids or other Infectious Material

What Is a Significant Exposure Under the Arizona Workers’ Compensation Act?

Northern Arizona University (NAU) has established this directive to guide employees (and their supervisors) in response to a significant exposure at work, which generally means contact of an employee’s ruptured or broken skin or mucous membrane with another person’s blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood or other potentially infectious material.

If you believe that you have had a significant exposure, promptly initiate the following steps:

1. First aid:
   - Wash needle sticks and cuts with soap and water.
   - Flush splashes to the nose, mouth, or skin with water.
   - Irrigate eyes with clean water, saline, or other sterile irrigant.

2. Notify your Supervisor as soon as possible.

3. At the earliest opportunity, preferably within 24 hours of your exposure, complete the Online Report of Injury form with your supervisor, and submit the completed form to NAU Human Resources (HR). Retain a copy for your records. HR will submit this document to Arizona State Risk Management.

4. Seek medical attention. NAU Employees who experience exposure at work will receive standard medical testing as prescribed for the exposure at no cost to the employee. If an infection occurs as a result of your exposure, a workers’ compensation claim will be opened within the provisions of the Arizona Workers’ Compensation Law, and the rules of the Industrial Commission of Arizona. Note: An employee must consult a physician to support a claim. Arrange to see one of the following Health Care Providers (HCPs) with working knowledge of NAU’s Significant Work Exposure Protocol:
   - NAU Campus Health Services
   - Concentra Medical Center
   - Flagstaff Medical Center (for afterhours emergencies)

5. If you have specific information about the infectious agent to which you were exposed, or a current vaccination record, make those available to the HCP at the time of your first visit.

6. Inform the HCP that fees incurred for vaccinations, lab work or treatment as a result of this exposure will be covered by Northern Arizona University and should be sent to: NAU Human Resources, PO Box 4113, Flagstaff, AZ 86011
Additional Resources:
Environmental Health and Safety, Director of Biosafety 928-523-7268
NAU Human Resources 928-523-2223
NAU Campus Health 928-523-2131
Industrial Commission of Arizona 602-542-4661
STATE OF ARIZONA
REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS

(THE IS NOT A CLAIM FORM)

Name
Last
First
M.I.
Social Security
Birth Date
Phone No.

1. Address
City
State
Zip

2. Agency Name
Phone No.

3. Agency Address

4. Date of Exposure
Time of Exposure
A.M.
P.M.

5. Address or Location of Exposure

6. Job Title

7. State fully how exposure occurred (be specific)

8. List all persons present at the exposure whom you can identify.

9. What bodily fluid were you exposed to?
   Blood
   Vaginal fluid
   Semen
   Surgical fluid(s)
   Any other fluid(s) containing blood (Describe)

10. Who did the bodily fluid come from?
    (Explain)

11. 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.

12. Did exposure to bodily fluid take place through your (a) skin or (b) mucous membrane?

13. 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 THE EXPOSURE.
D. YOU MUST FILE A WORKERS' COMPENSATION 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 COMPLETE FORM.

EMPLOYEE SIGNATURE:

DATE

This form approved by the Industrial Commission of Arizona for carrier use

Agency: Keep white original

ADOA Risk Management: Send pink copy

Employee: Keep yellow copy

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