

APPENDIX F

CONTAGIOUS DISEASE EXPOSURE REPORT FORM

This form must be faxed to the County Health Officer immediately.

FIELD PERSONNEL ONLY	Agency: _____ Agency Report Number: _____
	Name(s) of exposed: 1. _____ DOB _____ 2. _____ DOB _____ 3. _____ DOB _____ 4. _____ DOB _____
	Immunized for Hepatitis B? (Yes or No) 1. _____ 2. _____ 3. _____ 4. _____
	Date/Time of Exposure: _____
	Describe Exposure: (Cuts, wounds, abrasions, airborne) 1. _____ 2. _____ 3. _____ 4. _____
	Workers Compensation Provider (if known): _____
	Source Name: _____ DOB _____ Source transported to: _____ Reason for transport: _____
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	Ryan White Officer / Supervisor Name:(please print) _____ Date: _____
	Title: _____ Contact Phone #: _____ FAX #: _____
FAX this form to 781-5543 immediately	
COUNTY HEALTH AGENCY ONLY	RECOMMENDATIONS BY COUNTY HEALTH OFFICER
	<input type="checkbox"/> No evidence of communicable disease requiring follow-up
	<input type="checkbox"/> Follow-up of exposed workers recommended as follows:
	Follow-up indicated for _____ no follow-up indicated for _____.
	_____ _____ _____
Signature – County Health Officer _____ Date _____	

Return this copy to the Reporting Agency

One Copy to: CHO

One Copy to: Filing Agency