**Occupational Exposure to Bloodborne Pathogens Resources**

**Chapter 296-823 WAC**

**Helpful Tools**

**Health Care Professional’s Written Opinion for Post-Exposure Evaluation**

| Employee’s Name: | Click or tap here to enter text. |
| --- | --- |
| Date of Incident: | Click or tap here to enter text. |
| Date of Evaluation: | Click or tap here to enter text. |
| Health Care Professional’s Address and Telephone Number | Click or tap here to enter text. |

The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.

The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Hepatitis B vaccination  is indicated

is not indicated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Professional’s Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Professional’s Signature Date

**Return this form to the employer and provide a copy to the employee within 15 days. Please label the outside of the envelope “CONFIDENTIAL.”**

Employer’s Name: Click or tap here to enter text.

Employer’s Address: Click or tap here to enter text.

Confidential Fax: Click or tap here to enter text.

**Health Care Professional’s Written Opinion for Hepatitis B Vaccination**

| Employee’s Name: | Click or tap here to enter text. |
| --- | --- |
| Date of Evaluation: | Click or tap here to enter text. |
| Health Care Professional’s Address and Telephone Number | Click or tap here to enter text. |

As required by the Occupational Exposure to Bloodborne Pathogens rule, Chapter [296-823](https://www.lni.wa.gov/safety-health/safety-rules/chapter-pdfs/WAC296-823.pdf) WAC:

Hepatitis B vaccination **is** recommended for the employee named above.

**is not**

The employee named above is scheduled to receive 3 hepatitis B vaccinations on the following dates:

1st of 3 Click or tap here to enter text.

2nd of 3 Click or tap here to enter text.

3rd of 3 Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Signature and Date

**Return this form to the employer, and provide a copy to the employee, within 15 days. Please label the outside of the envelope “CONFIDENTIAL.”**

Employer’s Name: Click or tap here to enter text.

Employer’s Address: Click or tap here to enter text.

Confidential Fax: Click or tap here to enter text.