**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.