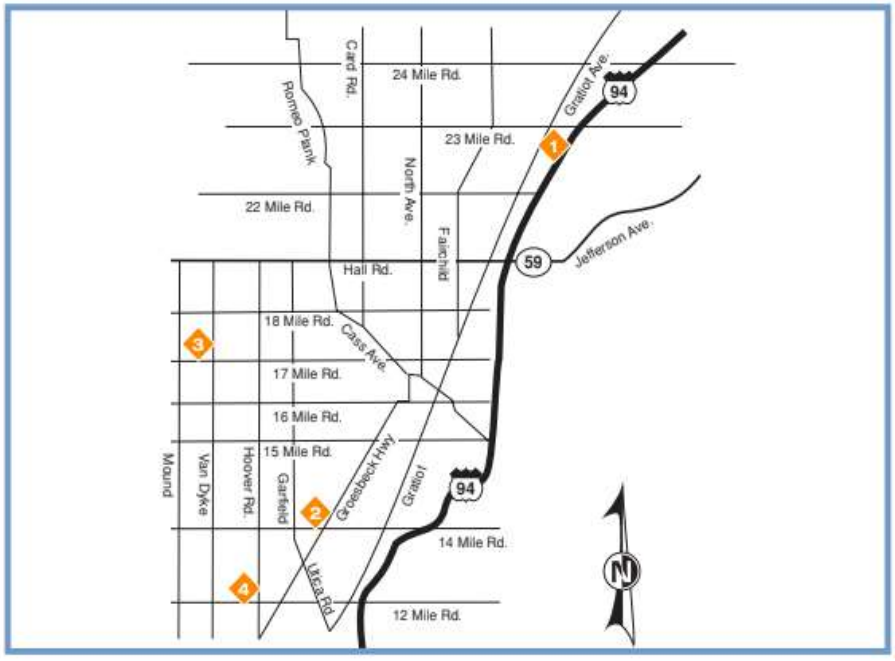
ALL BLOODBORNE EXPOSURES GO DIRECTLY TO Concentra Medical Center

Concentra®

Macomb County Locations



1. **Chesterfield**
   50110 Gratiot Ave
   Chesterfield, MI 48051
   Mon-Fri: 8 am - 5 pm
   Ph: 586.949.6336
   Fx: 586.949.0206

2. **Fraser**
   33089 Groesbeck Hwy
   Fraser, MI 48026
   OPEN 24/7 for
   New Injuries/Drug Screens
   24 hours, 7 days a week
   Ph:586.296.2800
   Fx: 586.296.6190

3. **Sterling Heights**
   39333 Van Dyke Ave
   Sterling Heights, MI 48313
   Mon-Fri: 7 am - 7 pm
   Sat: 10 am - 4 pm
   Ph: 586.977.1510
   Fx: 586.977.3261

4. **Warren**
   11569 E 12 Mile Rd
   Warren, MI 48093
   Mon-Fri: 7 am - 7 pm
   Sat: 10 am - 4 pm
   Ph: 586.582.0018
   Fx: 586.582.0108

Packet contains the following information:

- Leave Message flyer
- Distribution Of for all forms
- Employee Incident Report Form
- Employee Incident Witness Form
- Bloodborne Pathogen/Bodily Fluid Exposure Incident Report Form
- Source Individual Medical Release/Refusal Form
- Concentra Authorization for Treatment and Billing
- DCH-0675 packet

Leave message

24/7 for Human

Resources and

Labor Relations at

(586) 469-5650

for every Bodily

Fluid/Blood

Borne Exposure

Case

Distribution of Bloodborne Pathogens Exposure Forms

Form		Department	Human Resources	Employer Clinic
1)	Employee Injury and Illness Incident Report	Copy	Fax ASAP Send Original	N/A
2)	Employee Incident Witness Form	Copy	Fax ASAP Send Original	N/A
2)	Macomb County Bloodborne Pathogen/Bodily Fluid Exposure Incident Report Form	Original	Fax ASAP Send Copy	Copy must accompany Employee to clinic
3)	Macomb County Bloodborne Pathogens Source Individual Medical Release/Refusal Form	Original	Fax ASAP Send Copy	Copy must accompany Employee to clinic
4)	Authorization for Treatment and Billing	N/A	N/A	Original

Mark A. Hackel
County Executive

Employee Incident Report Form

FORM MUST BE FILLED OUT COMPLETELY

** Form should be filled out by injured employee. If injured employee is unable to fill out form within specified time period, the immediate supervisor should fill it out to the best of his/her ability. Please use your discretion.**

☐ Check box if completing form FOR injured employee

Section 1: EMPLOYEE INFORMATION

Employee Name: _____ Date of Birth: _____

Home Address: _____ Telephone Number: _____

Job Title: _____ Department: _____ Employee ID #: _____

Check All That Applies: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Contract Employee

Section 2: INCIDENT INFORMATION

Incident Date: _____ Time of Incident: _____ ☐am ☐pm Time Shift Began: _____ ☐am ☐pm

Incident Reported to: _____ Date/Time Incident Reported: _____

Part of Body Injured (specific): _____

Type of Incident (check all that apply):

☐ Slip/Trip/Fall ☐ Extreme Temperature ☐ Repetitive Motion ☐ Material Handling

☐ Laceration ☐ Striking an Object ☐ Abrasion/Bruise ☐ Blood Borne Exposure

☐ Sharp Object ☐ Puncture ☐ Assault/Restraint ☐ Bite

☐ Other: _____

Injured on County Property: ☐ Yes ☐ No (Specify Address) _____

Incident Location (i.e. lobby, hallway, etc): _____

Action Taken: ☐ First Aid ☐ Employer Clinic ☐ Hospital (Specify) _____

# of Employees Involved: ____ # Injured/Ill: ____ # Fatalities: ____

_____

_____

_____

_____

_____

Section 3: WITNESS INFORMATION (If, any)

Witnesses (Name & Phone Number): _____

WITNESS (If Any) Please Fill Out Supplemental Witness Form

Section 4: CORRECTIVE ACTIONS (To be filled out by immediate supervisor)

What Action Can Be Taken to Prevent Incident Reoccurrence?

- ☐ Equipment/Machinery Modification or Maintenance
- ☐ Improve Design/Construction
- ☐ Change to Work Procedure
- ☐ Improve Housekeeping
- ☐ Improve Work Organization
- ☐ Improve Personal Protection
- ☐ Enhance Training and Instruction
- ☐ Use of Safer Material
- ☐ Re-Training
- ☐ Other: _____

Specify Measures Already Taken: _____

Comments: _____

_____

_____

Section 5: SIGNATURES

Name of Immediate Supervisor (Printed): _____ Phone #: _____

Signature of Immediate Supervisor: _____ Date: _____

Name of Department Head (Printed): _____ Phone #: _____

Signature of Department Head: _____ Date: _____

AUTHORIZATION FOR PATIENT RECORDS

I, the undersigned, do hereby authorize by my signature on this injury and illness report, any hospital, physician, or other person who has attended me or examined me regarding the injury/illness described above to furnish the Macomb County, or its representative, any and all information with respect to this injury/illness and medical history, consultation, prescription, or treatment, and copies of all hospital or medical records of prior injuries/illnesses similar to this one. A photo static copy of this Authorization shall be considered as effective and valid as the original.

Signature of Employee: _____ Date: _____

Please immediately scan and email these documents to: employeeincidentreport@macombgov.org or fax them to (586)469-6974 **and** forward the originals via interoffice mail to Human Resources and Labor Relations. These forms must be returned IMMEDIATELY after completion or within 24 hours of the Incident/Injury/Illness.

Mark A. Hackel
County Executive

Employee Incident Witness Form

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Section 1: WITNESS INFORMATION

Witness Name: _____

Do you work for Macomb County: ☐ Yes (Specify Department) _____ ☐ No

Section 2: INCIDENT INFORMATION

I ☐ WAS or ☐ WAS NOT in the near vicinity of the incident when it happened. If near vicinity, list names of those persons you actually saw in the vicinity at the time of the occurrence.

_____

_____

_____

If you were not in the area when the incident occurred, but in another pertinent area, please give your location and the names of persons you saw, or believe were present, in your area.

_____

_____

_____

Are you the supervisor of the injured employee? ☐ Yes ☐ No

Give a factual statement of your actions and observations, before, during, and following the incident. Be as specific as possible.

_____

_____

_____

_____

_____

Section 3: SIGNATURES

Witness Name (Printed): _____

Witness Signature: _____ Date: _____

Witness Phone Number: _____

Please immediately scan and email these documents to: employeeincidentreport@macombgov.org or fax them to (586)469-6974 **and** forward the originals via interoffice mail to Human Resources and Labor Relations. These forms must be returned IMMEDIATELY after completion or within 24 hours of the Incident/Injury/Illness.

Macomb County
Bloodborne Pathogen/Bodily Fluid Exposure
Incident Report Form

Name of Exposed Worker: Last:_____ First:_____ Employee ID:_____

Name of person completing this form: _____ Job Title:_____

1) Date of Exposure: _____ 2) Time of Exposure: _____ ☐ AM ☐ PM

3) Location where exposure occurred: _____ 4) Home Department: _____

5) What is the job category of the exposed/injured worker: (check one box only)

☐ Deputy	☐ Animal Control Worker	☐ Clinician	☐ Probation Officer
☐ Corrections Deputy	☐ Environmental Service Worker	☐ Doctor	☐ Dispatcher
☐ Command Officer	☐ Youth Specialist	☐ Nurse/CNA	☐ Transporter
☐ Security	☐ Teacher/Teacher's Aide	☐ Dentist/Hygienist	☐ Other:_____

6) Did the exposure/injury occur?

☐ Due to a sharp object on Subject	☐ Before use of item (item broke/slipped, assembling devise, etc.)
☐ Subject scratched/scraped injured worker	☐ During use of item (item slipped, patient jarred item, etc.)
☐ Restraining Subject	☐ Sharp item left on floor, table, bed or other inappropriate place
☐ Subject bit exposed/injured worker	☐ Other after use-before disposal (in transit to trash, cleaning, sorting, etc.)
☐ Subject spit on exposed/injured worker	☐ Disassembling a device or equipment
☐ While recapping used needle	☐ While putting item into disposal container

☐ Withdrawing a needle from rubber or other resistant material (rubber stopper, IV port, etc.)

7) Where did the incident occur?

☐ Resident's Room	☐ Service/Utility (ex: supply room)
☐ Correctional Facility/Jail	☐ Clinical Laboratories
☐ Outside Building	☐ Exam Room
☐ Autopsy/Pathology	☐ Other _____

8) Was the source subject identifiable? (check one box only, example of source subject may be an animal, inmate, resident, object, etc.)

☐ Yes Name: _____ ☐ No ☐ Unknown ☐ Not Applicable

9) If yes, was a Source/Individual Medical Release/Refusal Form completed? ☐ Yes ☐ No ☐ Not Applicable

10) What type of device or item caused the exposure/injury?

☐ Needle- Kind:_____	☐ Lancet	☐ Razor	☐ Scissors	☐ Pin
☐ Needle, not sure what kind	☐ Glass	☐ Fingernails	☐ Teeth	☐ Wire
☐ Sharp object, type unknown	☐ Other device or item, describe _____			

11) Was the exposed/injured worker the original user of the device or item?

☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

12) The device or item was:

☐ Contaminated (known exposure to subject or contaminated equipment)

☐ Uncontaminated (no known exposure to subject or contaminated equipment) ☐ Unknown

13) If contaminated, was blood or bodily fluid on the device? ☐ Yes ☐ No

14) For what purpose was the device or item originally used? (check one box only)

☐ Unknown / Not applicable	☐ To establish intravenous or arterial access
☐ Finger stick	☐ To access established intravenous or arterial line
☐ Suturing ☐ Cutting	☐ Injection, intra-muscular/subcutaneous or other injection through the skin
☐ To obtain blood specimen (through skin)	☐ Other specimen collection type _____

☐ Other, describe: _____

15) Was the exposed worker offered transportation to receive medical treatment? ☐ Yes ☐ No

16) Was the exposed worker offered laundry/sterilization services for their contaminated clothing or belongings? ☐ Yes ☐ No ☐ Not Applicable

17) Was the employee injured? ☐ Yes ☐ No

18) Was an Employee Incident Report completed? ☐ Yes ☐ No

19) Use the space below to provide any additional information regarding how the exposure occurred and how it might have been prevented:

_____

_____

_____

_____

Macomb County
Bloodborne Pathogens
Source Individual Medical Release/Refusal Form

1 S. Main Street, 6th Floor
Mt. Clemens, MI 48043
(586)469-5280

Source Information

Name (Last, First, Middle)	Address	City, ST Zip

You have been (or your child has been) involved in an incident that has exposed the following employee(s) to your blood or body fluids (or your child's blood or body fluids):

Name (Last, First, Middle)	Employee ID
Name (Last, First, Middle)	Employee ID
Name (Last, First, Middle)	Employee ID

Permission for Source Individual's Medical Release

I hereby grant permission to have my blood (or my child's blood) drawn and tested to determine if I am (or my child is) a carrier of bloodborne disease. I also grant permission to have the test results released to the individual(s) listed above, and to the health care providers performing the follow-up evaluations.

_____ _____

Source Individual (Parent/Guardian) Signature Date

Refusal for Source Individual's Medical Release

I have had the exposure evaluation process explained to me and I hereby refuse to consent to blood testing to determine my (or my child's) infectious status with regard to bloodborne pathogens, including but not limited to Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), or Human Immunodeficiency Virus (HIV). I understand that by refusing to do so, the individual or individuals who were exposed to my (or my child's) blood or body fluids will have limited information to determine their potential for contracting these diseases.

_____ _____

Source Individual (Parent/Guardian) Signature Date

Concentra Medical Center

AUTHORIZATION FOR TREATMENT AND BILLING

Worker's Compensation Injuries or Exposure

Company: Macomb County - Injury Telephone #: (586) 469-5280 Fax #: (586) 469-6974

Address: 1 S Main St., 6th Floor (Street) Mt. Clemens (City) MI (State) 48043 (Zip)

Work Comp Carrier: Comprehensive Risk Services Telephone #: (800)737-9875 Fax #: (248)344-8560

Address: P.O. Box 505 (Street) Novi (City) MI (State) 48376 (Zip) Policy Number: WCX 002856

Designated Employer Rep: See Employer Notes Telephone #: (586) 469-5280 Fax #: (586) 469-6974

Employee: _____ SS#: _____ DOB: _____

Department _____ Location: _____

Authorization for:

☐ BBP Exposure **- OR -** ☐ Care of Injury **AND** Brief Description _____

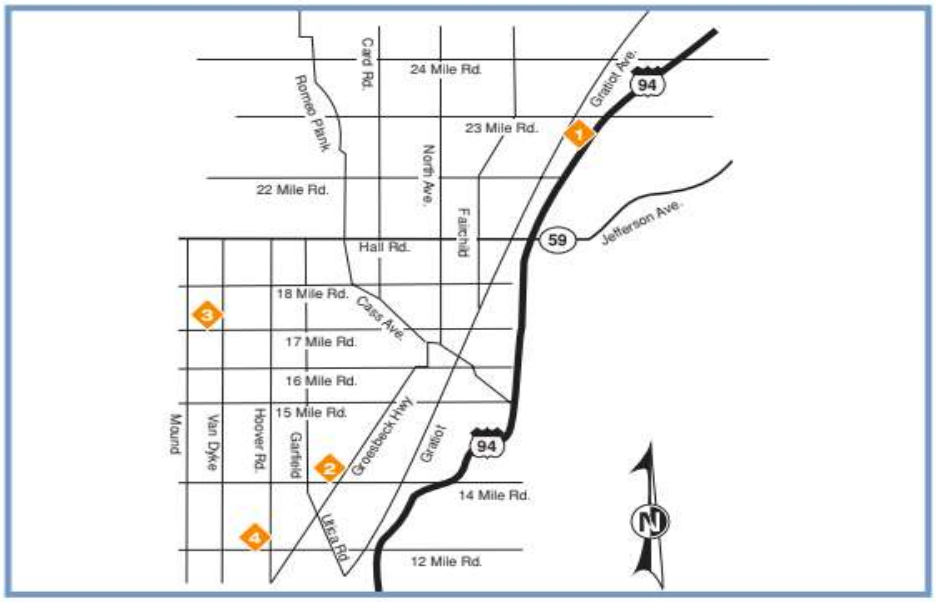
Authorization by: _____ Position or Title: _____

Date: _____ (the authorizing individual may be contacted for additional information regarding the incident)

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby give consent to Concentra Medical Center and the attending physician for examination and treatment and authorize release of information pertaining to this specific or physical examination to my employer or employer's insurer.

EMPLOYEE SIGNATURE: _____ **DATE:** _____



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   Mon-Fri: 7 am - 7 pm
   Sat: 10 am - 4 pm
   Ph: 586.582.0018
   Fx: 586.582.0108

What if I have more questions?

- Feel free to **ask the health professional who gave you this booklet** any questions that you might have.
- **Call the Michigan statewide HIV/AIDS information hotline** (English 1-800-872-AIDS; Español 1-800-862-SIDA; TDD 1-800-332-0849).
- **Visit the CDC's HIV/AIDS website** for more information (http://www.cdc.gov/hiv/).

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

MDCH is an equal opportunity employer, services and program provider.

175,000 printed at 9.0 cents each with a total cost of $15,191.10

5/10

WHAT YOU NEED TO KNOW

About HIV Testing

What is HIV and how is it spread?

HIV infection is a long-term illness that damages the body's immune system, or its ability to fight off diseases. HIV spreads through blood, semen, vaginal fluids, and breast milk. You can get or give HIV infection by:

- Having vaginal, anal, or oral sex without a condom.
- Sharing needles or works when injecting drugs.
- HIV can be passed from mother to child during pregnancy, birth or breastfeeding.
- You **cannot** get HIV by donating blood or through casual contact such as hugging or shaking hands.

What is AIDS?

- AIDS (Acquired Immunodeficiency Syndrome) is the stage of HIV infection when the body is weakened and less able to fight off germs.

What is an HIV test?

It is a simple test, done by taking blood or fluid from cells in the mouth, that shows if you have been infected with HIV (human immunodeficiency virus), the virus that causes AIDS.

Who should have an HIV test?

- The CDC (Centers for Disease Control and Prevention) recommends that everyone between the ages of 13 and 64 get tested for HIV.
- Whatever your age, you should have an HIV test if you are sexually active or have shared needles or works for injecting drugs.
- Women who are pregnant or considering pregnancy should also get an HIV test.

Can anyone make me take an HIV test?

Under Michigan law, unless you are ordered by a judge, or you are a prisoner entering into a state correctional facility, getting an HIV test is your decision. No one can test you without getting your consent.

Can I change my mind after I consent to the test?

- **Yes**, you can change your mind at any time before the lab runs the test.
- If you change your mind, you must give your health care provider a written request saying that you do not want your test to be run.

Can someone under age 18 take the test without their parents' consent?

- Yes. Minors, age 13 and older, have the right to take the test for HIV without their parents' knowledge or consent.

What is the difference between anonymous and confidential testing?

- **Anonymous HIV testing** means your name is not used and will not be on the test results. To get your test results, you will be given a code number.
- **Confidential HIV testing** means that your name will be used on your test results.
- If you get an anonymous HIV test, you will not receive a piece of paper with your name and your test results. If you need a copy of your HIV test results, you should take a confidential test.

In Michigan, you have the right to request an anonymous HIV test.

How is HIV testing done?

Typical HIV tests are done on blood or oral fluids. Specimens are sent to a lab and you get your results in about one week. When testing blood, a needle will be used to draw blood from a vein in your arm. When testing oral fluids, they are collected on a swab from your mouth.

Rapid test: Some clinics or testing sites offer rapid testing. This is a test done on a small amount of blood from the tip of your finger or from fluid in your mouth. You will get results in that same visit. If your result is reactive (shows possible signs of infection), you will need more testing.

How will this test help me?

- The test will tell you whether or not you have HIV. People can have HIV for years and not know it unless they get tested.
- If you **are infected**, it can help you get proper treatment and learn how to avoid spreading HIV to other people.
- If you **are not infected**, it can help you learn how to reduce your risk of getting HIV.

What does a negative (or "non-reactive") result mean?

- A **negative result** means you are not infected with HIV,
- OR you have been infected too recently for it to show up on the test.
- If you recently had sex without a condom or shared needles, you should get another test in about six weeks. This is because sometimes HIV tests cannot detect recent infection.

What does a positive result mean?

- A **positive result** means that you are living with HIV.
- You should see a doctor as soon as possible. The person who gave you your test results can help you find a doctor if you don't have one.
- If you have HIV, you can pass your infection to other people through sex, sharing needles, or through birth or breastfeeding if you are or will be a mother.
- You should use condoms every time you have sex, to prevent passing the infection to others. The person who gave you your test results can help you plan ways to keep from passing your infection on to others.

Who will know the results of my test?

In Michigan, all HIV test information is confidential, by law.

- This means that there are very strict rules about who is allowed to see that information.
- Health care workers that are involved in your care may see your test results.
- Health insurance companies, Medicare and Medicaid, if they are paying all or part of the cost of your health care, will also see your test results.
- All positive HIV tests are reported to the health department.
- If you have HIV, Michigan law requires that your doctor or someone from the local health department notify all of your known sexual and/or needle-sharing partners that they may have been exposed to HIV. They do this without using your name, or sharing any information about you.
- It is illegal to discriminate against people with HIV.

If I have HIV, will I definitely develop AIDS or get sick?

No. Today there are many treatments for HIV. These treatments can prevent serious illness, including AIDS. If you get care quickly, you have a good chance for a long and healthy life

Whom should I tell if I have HIV?

- Current, past and future sexual and/or needle-sharing partners should be notified.
- Your local health department can also help to notify partners. They will do this without using your name or sharing any information about you. Your doctor, health care provider or counselor that performed the test can connect you with the local health department.

Michigan law requires you to tell any current or future sexual partner that you have HIV before having any kind of sex with them.

- The law also requires that your doctor or someone from the local health department talk to you about this.