APPENDIX V

OSWEGO COUNTY OPPORTUNITIES, INC.

EMPLOYEE MEDICAL EVALUATION FORM
WORKSITE BLOOD/BODILY FLUIDS EXPOSURE
(EMPLOYEE TAKES TO PHYSICIAN)

Employee Name:_____ DOB:_____ SSN :_____-____-_____

Building Assignment and
Function:_____

TO THE PHYSICIAN:

The employee named above has indicated that he/she has had blood/bodily fluids exposure while at work. Please complete the required information listed below. This form must be returned to the employer/employee within 15 working days to:

Human Resources Department – Worker's Comp Specialist
Oswego County Opportunities, Inc.
239 Oneida Street
Fulton, NY 13069

1. Hepatitis B Prophylaxis recommended?
   ____ YES
   ____ NO

2. HIV Prophylaxis recommended?
   ____ YES
   ____ NO

3. Employee has been informed of results of the evaluation?
   ____ YES
   ____ NO

4. Employee advised to contact their private physician for follow-up care and treatment?
   ____ YES
   ____ NO

5. Is lost time indicated?
   ____ YES
   If yes, please explain and/or list dates:_____
   ____ NO

Any additional findings must be kept confidential.

_____ _____ _____
Signature of Evaluator Time Date