FORMS

CITY OF OVIEDO

Acknowledgement of Job Safety Instructions

For New or Transferred Employees

The following Safety Procedures were fully discussed with _____as a requirement for his/her job as _____ in the Department of _____.

CHECK ITEMS THAT WERE FULLY DISCUSSED

1. Use of safety equipment* or special procedures _____
2. Work shoes needed _____
3. Correct job procedures and safety equipment. _____
4. Hazards of job _____
5. How to report unsafe Conditions _____
6. Safe use of Chemicals, materials, etc. _____
7. Good housekeeping _____
8. First Aid procedures _____
9. Safely videos _____
10. Reporting an injury, (how, when, where, who) _____
11. Authorized use of Vehicles _____
12. How to report an accident _____
13. Use and care of tools _____
14. No horseplay _____
15. Other* (Explain) _____
16. MSDS (Explain) _____
17. Seat Belts (Explain) _____

*Itemize specific equipment or special procedures on equipment or special procedures form.

I understand the job safety instructions and will cooperate to prevent accidents and injuries occurring to myself and my fellow workers.

I understand failure to abide by the rules of the safety manual and failure to wear and use issued safety equipment properly, will result in disciplinary action which could lead to termination.

_____ _____

Date Signature of Employee

_____ _____

Date Signature of Supervisor

Please return original to Human Resources.

SUPERVISOR'S CHECKLIST FOR WORKERS' COMPENSATION CLAIMS

MINOR INJURIES

Monday through Friday, 8am – 5pm:

____ Take injured worker to EHWC (CareHere Clinic). If it is closed, and if the injured employee needs immediate medical attention, proceed to CentraCare (address and times on back of checklist). All drug tests should be conducted at the EHWC whenever possible. ALWAYS have a drug screen completed within **32** hours of injury or illness.
____ Notify HR Analyst immediately at 407-971-5524 or email at ebereczki@cityofoviedo.net.
____ Complete Supervisor Accident Investigation Report for Workers' Compensation Injury form (employee, supervisor AND Director must review and sign). Use back of form for detail or witness statement. Do a complete investigation.
____ If employee does NOT go to the EHWC, they must complete the Gallagher Bassett Statement and Authorization form.
____ If employee does NOT go to the EHWC, or is given a paper Rx from the EHWC, give the employee the Tmesys Rx Card.
____ Forward all forms, photos and records to Erica Bereczki, HR Analyst within 24 hours.

After Business Hours:

____ If treatment can't wait until the EHWC opens, take injured employee to CentraCare. All drug tests should be conducted at the EHWC whenever possible. ALWAYS have a drug screen completed within **32** hours of injury or illness.
____ Notify Erica Bereczki, HR Analyst via voice mail and email (contact info is below).
____ Complete Supervisor Accident Investigation Report for Workers' Compensation Injury form (employee, supervisor AND Director must review and sign). Use back of form for detail or witness statement. Do a complete investigation.
____ Employee must complete the Gallagher Bassett Questionnaire and Authorization form. Give the employee the Work Comp Tmesys Rx Card.
____ Forward all forms, photos and records to Erica Bereczki, HR Analyst within 24 hours.

SERIOUS INJURIES (unconscious, loss of limb, sight or severe break, neck or back injury):

Monday through Friday, 8am – 5pm:

____ **Call 911**
____ Notify Department Director immediately.
____ Notify Erica Bereczki, HR Analyst immediately (contact info is below).
____ Complete Supervisor Accident Investigation Report for Workers' Compensation Injury form (employee, supervisor AND Director must complete). Use back of form for detail or witness statement. Do a complete investigation.
____ Employee must complete the Gallagher Bassett Questionnaire and Authorization form. Give the employee the Work Comp Tmesys Rx Card.
____ Send updates and all forms, photos and records to Erica Bereczki, HR Analyst within 24 hours.

After Business Hours:

____ **Call 911**
____ Notify Department Director
____ Notify HR Analyst at 407-790-6111. If you leave a message try to follow up with an email with a copy to the HR Director Connie Collins ccollins@cityofoviedo.net
____ Complete Supervisor Accident Investigation Report for Workers' Compensation Injury form (employee, supervisor AND Director to Complete). Use back of form for detail or witness statement. Do a complete investigation.
____ Employee must complete the Gallagher Bassett Questionnaire and Authorization form. Give the employee the Work Comp Tmesys Rx Card.
____ Send updates and all forms, photos and records to Erica Bereczki, HR Analyst within 24 hours.

OTHER ITEMS:

____If injury is a strain or sprain, complete the Supervisor Injury Investigation Strain Supplement form.
____Assist and accompany employee for drug screen & treatment & ensure employee has HR Analyst Contact info

HR Analyst – Erica Bereczki – 407-971-5524 or after hours 407-790-6111 - ebereczki@cityofoviedo.net

Serving Florida Public Entities

SUPERVISOR ACCIDENT INVESTIGATION REPORT FOR WORKER'S COMPENSATION INJURY

(PURPOSE TO PREVENT REOCCURRENCE)

The Report of Injury is to be submitted within 24 hours following the date of injury. If the employee is unable to complete his/her account of the accident, the supervisor is to provide information, in addition to the analysis of the accident.

EMPLOYEE'S ACCOUNT OF THE ACCIDENT

Employee's Name: _____ Department: _____ Classification Code: _____ Date: _____

Date of Accident: _____ Day of the Week: S M T W Th F S Time of Accident _____ ☐AM ☐ PM Place of Accident: _____

In your own words, explain in detail, what you were doing immediately prior to the accident and then how you believe the accident happened. _____

Employee's Signature: _____

SUPERVISOR'S ANALYSIS OF THE ACCIDENT

Date/Time Employee reported injury _____ ☐ AM ☐ PM

Was Employee seen by a physician? ☐ Yes ☐ No ☐ Unknown

If yes, name of Physician/Hospital _____

Hospitalized? ☐ Yes ☐ No ☐ Unknown

Did Employee lose time from work (other than for medical treatment? ☐ Yes ☐ No If yes, date last worked: _____

Date Expected to Return: _____ Date Returned: _____

Nature of injury and part of body involved (e.g. cut left hand, strained back, bruised leg, etc.)

Name of Witnesses to the Accident:

1. _____ 2. _____

Do you concur with the Employee's account of the accident? ☐Yes ☐ No ☐ Unsure

If you answer no or unsure, please explain: _____

What factors do you believe were instrumental in causing the accident? Please explain your rationale:

Describe actions taken, planned or needed to prevent reoccurrence (example: job instruction, guard installed, tool repaired, improved inspection: _____

Supervisor Signature: _____ Date: _____

DEPARTMENT DIRECTOR REVIEW

☐ Investigation Sufficient ☐ Suggested additional actions on reverse ☐ Report to be submitted to Safety Committee

Department Director Signature: _____ **Date:** _____

Serving Florida Public Entities

SUPERVISOR'S INJURY INVESTIGATION – STRAIN SUPPLEMENT FORM

Employee Name: _____ Date of Injury: _____ Department Code: _____

Complete as a supplement to The Supervisor's Investigation Report, in cases involving complaint of back injury, suspected hernia or other unusual strain. This is an Investigative Report. Ask these questions as soon as possible after receiving report of injury. The purpose of this supplement is to assist you in developing a clear understanding of strain incidents.

1. Did the pain develop gradually or did you feel it all of a sudden? _____

IF THE PAIN WAS ACUTE (SUDDEN), USE QUESTIONS 2-7

2. Exactly what were you doing when the pain was felt? _____

3. Have you ever done this before? _____ If so, how often? _____

4. When you felt the pain, were you doing it the way you usually do? _____ If not, what was different? _____

5. Did anything unexpected, unusual or abnormal happen? _____ If yes, Explain: _____

6. When you felt the pain, did you tell anyone? _____ If so, who and when? _____

7. If nothing unexpected or unusual happened, how do you think the injury occurred? _____

_____

How would you explain why you were injured? _____

IF THE PAIN DEVELOPED GRADUALLY, USE QUESTIONS 8 – 14

8. When did you first notice the pain? _____

9. What had you been doing _____

10. How long, or how many times did you do this? _____

11. Have you ever done this before? _____ If so, how often? _____

12. Were you doing it the same way you usually do it? _____ If not, what was different? _____

_____

13. Except for the pain that developed, do you recall anything unusual, unexpected or abnormal that happened?

_____

14. If nothing unusual happened, what do you think causes the pain? How would you explain why you were injured?

_____

_____

Gallagher Bassett Services, Inc.

Statement of Employee Questionnaire

Name:_____ Date of Birth:_____ Social Security No: _____

Home Phone No:_____ Cell Phone No:_____ Work Phone No:_____

Home Address:_____

Email Address:_____

Height:_____ Weight:_____ Married?_____ Spouse Name:_____

Names & ages of dependents: _____

Employer's name & address:_____

Occupation:_____ Wages:_____ Gender:_____

Name & address of your family physician: _____

Date of accident:_____ Time:_____ Place:_____ Left/Right Handed:_____

Describe in detail what you were doing and what happened when the accident occurred:_____

_____

_____

Describe your injury:_____

List all Injured Parts of Body and the specific injury (e.g., bruised left hand)_____

_____

Names & addresses of witnesses or persons having some knowledge of accident: _____

_____

Name & address of attending physician:_____

Name & address of any other physicians you have seen as a result of this accident:_____

_____

Date of first visit:_____ Date of last visit:_____ Date of next visit:_____

Did you lose time from work?_____ List days missed from work:_____

Have you returned to work?_____ If so, when:_____ At what wage?_____

If you have not returned to work, please describe your present physical condition:_____

_____

If you have not returned to work, when do you expect to return to work? _____

Have you ever had a previous injury resulting in permanent impairment or partial disability?_____

If so, please describe same: _____

FRAUD WARNING: "Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program, files a statement of claim containing any false or misleading information is guilty of a Felony of Third Degree."

_____ _____

Employee Signature Date

Gallagher Bassett Services, Inc.

Name	Date of Birth	Social Security Number

Authorization for Medical, Wage and Social Security Release and Fraud Acknowledgement

This authorization or photocopy thereof, will authorize you to furnish **Gallagher Bassett Services, Inc.**, with all medical information you may have regarding my condition while under your observation or treatment including the history obtained, x-rays, physical findings, the diagnosis and prognosis, that can be reasonably related to my workers' compensation claim of insert date; and all information regarding my employment, all wages, fringe benefits and contract of employment.

Notice to Employee: This form has been provided to you to supply your Authorization for Release of Information pertaining to Social Security Disability Benefits. The Florida Workers' Compensation Law, F.S. §440.15 (10) requires you to furnish this Authorization. ***Should you fail to return this form, your compensation payments will stop until you comply with this request.***

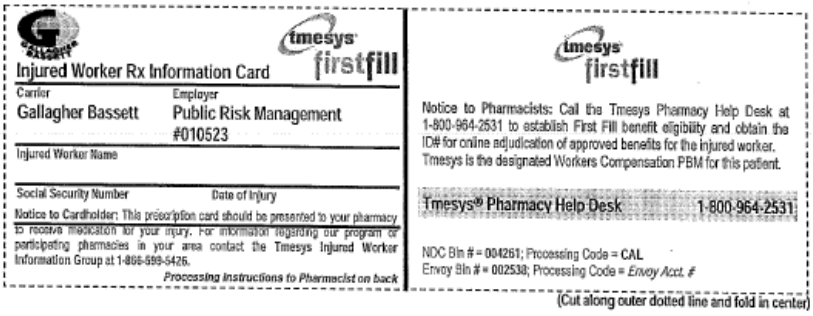
I authorize the Social Security Administration to release my Master Beneficiary Record and other information which may not be included in my Master Beneficiary Record such as entitlement dates, monthly amounts, P.I.A., family maximum and average current earnings for myself and my dependents to **Gallagher Bassett Services, Inc.**

A photocopy of this authorization is to be considered as valid as the original and is effective for **one year** from the date signed.

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

FRAUD WARNING: "Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program, files a statement of claim containing any false or misleading information is guilty of a Felony of Third Degree." I have reviewed, understand and acknowledge the above statement.

Signature	Date



Injured Worker Rx Information Card

Carrier: Gallagher Bassett

Employer: Public Risk Management #010523

Injured Worker Name

Social Security Number

Date of Injury

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the Tmesys Injured Worker Information Group at 1-866-599-5426.

Processing Instructions to Pharmacist on back

Notice to Pharmacists: Call the Tmesys Pharmacy Help Desk at 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker. Tmesys is the designated Workers Compensation PBM for this patient.

Tmesys® Pharmacy Help Desk 1-800-964-2531

NDC Bin # = 004261; Processing Code = CAL

Envoy Bin # = 002538; Processing Code = *Envoy Acct. #*

(Cut along outer dotted line and fold in center)

Your employer and Gallagher Bassett your workers' compensation claims administrator, are providing prescription benefits through Tmesys, an Online Pharmacy Benefits Manager.

Dear Newly Injured Worker:

The attached cut-out Tmesys First Fill card will make the process of obtaining medications for your injury easier and more convenient. Simply present this card to any of our more than 50,000 participating pharmacies nationwide, including Hawaii and Puerto Rico, and your prescription will be filled at no out-of-pocket expense to you!

Your use of this card is limited to those prescriptions medically related to an injury that is considered to be covered under the applicable state workers' compensation law.

Should you have any questions regarding our program or for the locations of a participating network pharmacy near you please contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426**.

Sincerely,
Tmesys, Inc.

How to locate a Tmesys Pharmacy:

1. Call the **Tmesys Injured Worker Information Group** at **1-866-599-5426**. A Tmesys representative will be more than happy to assist you with the location of a participating pharmacy in your area.
2. Visit our pharmacy locator on the web at www.tmesys.com, under the "Resource Center" tab, to the left of your screen you'll find the "**Tmesys Pharmacy Locator**."

Tmesys, Inc.
P.O. Box 152539
Tampa, FL 33684-5239

SUPERVISORS CHECKLIST FOR AUTO ACCIDENTS

NOTIFICATION DURING HR BUSINESS HOURS:

NO BODILY INJURY:

STEPS

____ 1. If City employee is in the vehicle at the time of the accident, a drug screen must be completed within **32** hours at the Employee Health and Wellness Center (alternate locations and facility times are listed on back). The EHWC is the preferred provider. The employee may NOT drive a City vehicle until the drug screen results are verified.
____ 2. Notify Erica Bereczki, HR Analyst immediately at 407-971-5524 and email ebereczki@cityofoviedo.net.
____ 3. File a police report. Notate if the police do not come out for minor incidents.
____ 4. Obtain witness statements.
____ 5. Complete Supervisor Investigation Report Motor Vehicle; review/ approval by Department Director is required.
____ 6. Employee and supervisor complete Gallagher Bassett Accident Report, Auto and Truck and submit to HR.
____ 7. Take photos of vehicles, scene and any other conditions leading to accident.
____ 8. If drivable, take City vehicle to Fleet for inspection. If not drivable, contact Fleet at x5661 for instructions.
____ 9. Forward all forms, photos, police reports and records to Erica Bereczki, HR Analyst within 24 hours.

BODILY INJURY - EMPLOYEE

____ Call 911.
____ Follow and complete steps 1-9 above.
____ Also follow the Supervisors Checklist for Worker's Compensation.

BODILY INJURY – NON -EMPLOYEE

____ Call 911.
____ Follow and complete Steps 1-9 above.
____ Complete the Supervisors Checklist for Liability Claims

NOTIFICATION AFTER HR BUSINESS HOURS:

NO BODILY INJURY:

____ Follow and complete steps 1-9 above.
____ Leave message with Erica Bereczki, HR Analyst at 407-971-5524 and email ebereczki@cityofoviedo.net.

BODILY INJURY - EMPLOYEE

____ Call 911.
____ Follow and complete Steps 1-9 above.
____ Follow the Supervisors Checklist for Worker's Compensation

BODILY INJURY – NON -EMPLOYEE

____ Call 911.
____ Follow and complete Steps 1-9 above.
____ Complete the Supervisors Checklist for Liability Claims

HR Analyst – Erica Bereczki – 407-971-5524 or after hours 407-790-6111 - ebereczki@cityofoviedo.net

SUPERVISOR'S INVESTIGATION REPORT
MOTOR VEHICLE

Serving Florida Public Entities

The unsafe acts of drivers and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and name them and to state the remedy for them in this report.

Code: _____

COMPANY / CITY / COUNTY	TERMINAL OR DIVISION
DRIVER	TYPE OF VEHICLE
LOCATION OF ACCIDENT (STREET, TOWN, STATE)	DATE AND TIME OF ACCIDENT
NO. OF PERSONS INJURED AND EXTENT OF PROPERTY DAMAGE (COMPANY AND OTHER)	
DESCRIPTION OF ACCIDENT (IN DETAIL WHAT OCCURRED JUST BEFORE, AND AT THE TIME OF ACCIDENT):	
UNSAFE CONDITION (DESCRIBE CONDITIONS SUCH AS FAULTY BRAKES, LIGHTS, ETC. CONTRIBUTING TO THE ACCIDENT):	
REMEDY (AS A SUPERVISOR, WHAT ACTION HAVE YOU TAKEN, OR DO YOU PROPOSE TAKING TO PREVENT A REPEAT ACCIDENT)	

SUPERVISOR	REVIEWED AND APPROVED BY	DATE REPORT PREPARED

USE REVERSE SIDE FOR SKETCH AND ADDITIONAL DETAIL

Immediately after an accident fill out this form and send to:
PUBLIC RISK MANAGEMENT OF FLORIDA
3434 Hancock Bridge Pkwy., Ste. 203
Fort Myers, FL 33903
PHONE: 239-656-4666 FAX: 239-656-1066

LOCATION CODE

ACCIDENT RESULTED IN:
☐ BODILY INJURY ☐ PROPERTY DAMAGE

GALLAGHER BASSETT SERVICES, INC.
ACCIDENT REPORT, AUTO AND TRUCK
(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

CLIENT

NAME	PHONE	DRIVER NAME			DATE OF BIRTH
ADDRESS		ADDRESS			NO. OF YEARS WITH COMPANY
CITY	STATE ZIP	CITY	STATE	ZIP	DRIVER'S LICENSE NUMBER

VEHICLE

MAKE	YEAR	MODEL	SERIAL NUMBER	LICENSE NUMBER	WHERE VEHICLE CAN BE SEEN
TRAILER IF APPLICABLE	YEAR	MODEL	AREA OF DAMAGE	USED FOR BUSINESS ☐ YES ☐ NO	ESTIMATED COST TO REPAIR $

ACCIDENT

DATE OF LOSS	TIME OF LOSS	LOCATION (STREET OR HIGHWAY)	CITY	STATE

WERE POLICE CALLED TO THE SCENE? ☐ YES ☐ NO	POLICE DEPT. CALLED	DRIVER	ARRESTED	TICKETED	VIOLATION
NAME OF OFFICER					
STATION ADDRESS					

CLAIMAINT 1

OWNER OF VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $	WHERE VEHICLE CAN BE SEEN

CLAIMAINT 2

OWNER OF VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $	WHERE VEHICLE CAN BE SEEN

PROPERTY DAMAGE OTHER THAN AUTO (i.e. FENCE, CANOPY)

OWNER OF PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE

WITNESS INFORMATION

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

PERSONS INJURED (USE ADDITIONAL SHEET IF NECESSARY)

NAME		AGE	NAME		AGE
ADDRESS		PHONE	ADDRESS		PHONE
CITY	STATE	ZIP	CITY	STATE	ZIP
OCCUPATION	WHERE TAKEN		OCCUPATION	WHERE TAKEN	

☐ FATALITY	☐ PEDESTRIAN	☐ FATALITY	☐ PEDESTRIAN
☐ BLEEDING OR DISTORTED WOUND	☐ IN YOUR VEHICLE	☐ BLEEDING OR DISTORTED WOUND	☐ IN YOUR VEHICLE
☐ UNCONSCIOUSNESS	☐ IN CLAIMAINT VEHICLE	☐ UNCONSCIOUSNESS	☐ IN CLAIMAINT VEHICLE
☐ NO VISIBLE INJURY – COMPLAINED OF PAIN		☐ NO VISIBLE INJURY – COMPLAINED OF PAIN	
☐ OTHER ____		☐ OTHER ____	

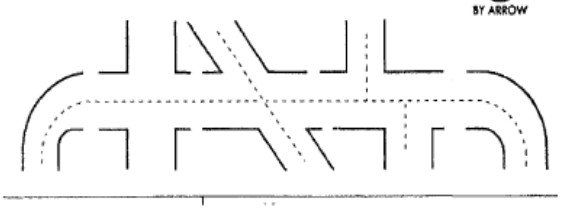
ADDITIONAL REMARKS

DESCRIBE ACCIDENT

VEHICLES ——— 1 2 ——— PEDESTRIAN ( )

ACCIDENT DIAGRAM

INDICATE NORTH BY ARROW



WHAT STREET WERE YOU ON?	CLAIMAINT 1	CLAIMANT 2
WHAT DIRECTION WERE YOU TRAVELING?	CLAIMAINT 1	CLAIMAINT 2

WEATHER CONDITIONS	TRAFFIC CONDITIONS
☐ DRY ☐ WET ☐ ICY ☐ FOGGY ☐ SNOWY	☐ LIGHT ☐ MODERATE ☐ HEAVY

SPEED LIMIT	WERE YOU FAMILIAR WITH THIS AREA	TRAFFIC CONTROLS
	☐ YES ☐ NO	

THIS SECTION MUST BE COMPLETED BY A SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? ☐ YES ☐ NO
2. IN MY OPINION, WE ARE AT FAULT FOR THIS ACCIDENT. ☐ YES ☐ NO

IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER? ☐ YES ☐ NO

IF REPORTED, NAME OF FIRM: _____
ADDRESS _____
DATE ASSIGNED _____

DATE OF THIS REPORT	SIGNATURE AND TITLE

SUPERVISOR'S CHECKLIST FOR EXPOSURE CASES

24 HOUR Post Exposure Nurse (PEN) Hotline through Florida Hospital

An exposure is contact on your skin, open wound, or in any orifice of your body with any bodily fluids, whether the source is known or not. This can include blood, saliva, urine, feces, vomit, tears, sweat, wastewater, syringes or blood on a weapon that caused injury to the employee. When in doubt, follow this checklist!

****Immediately wash the exposure area with soap and at least tepid water. Saline/water eye wash should be used if the eye is involved.****

If Supervisor is with the Employee at the time of the Exposure:

____ Supervisor should contact Division Chief Tim Koepsell and/or Fire Chief Lars White of the exposure. (See back for #'s) They will determine if the exposure warrants a call to the PEN Hotline.

If the Fire Chief or Division Chief advise to call the PEN Hotline, or if you DO NOT get a response from them within 10 minutes follow these steps:

____ 1. Supervisor should call the PEN Hotline **407-691-5490 #2 or 1-888-807-1020 #2.**

____ 2. Supervisor should notify their direct supervisor or department director of the blood borne exposure.

____ 3. Supervisor should wait with the employee until the PEN arrives. If onsite care is not needed, the supervisor will accompany the employee to the nearest Florida Hospital CentraCare or Emergency Room as directed by the PEN.

____ 4. If there is ever any question or doubt in regards to immediate treatment of an exposure, do not hesitate to contact the PEN Hotline at any time!

____ 5. **Complete the City of Oviedo Infectious Exposure Report Form (Be sure to document the source patient contact information!!!)**

____ 6. **Complete the Supervisor Checklist for Workers Compensation Claims**

____ 7. Unless otherwise directed by the PEN or Urgent Care physician to see a specialist, the employee must follow up and continue their exposure protocol through the EHWC.

If Supervisor is NOT with the Employee at the time of the Exposure:

____ Employee should contact Division Chief Tim Koepsell and/or Fire Chief Lars White of the exposure. They will determine if the exposure warrants a call to the PEN Hotline.

If the Fire Chief or Division Chief advises to call the PEN Hotline, if or you DO NOT get a response from them within 10 minutes:

____ Employee should call the PEN Hotline **407-691-5490 #2 or 1-888-807-1020 #2.** Follow the PEN instructions.

____ Employee should immediately notify their direct supervisor or department director of the blood borne exposure.

____ Supervisor follow Steps 2-7 above.

____ Supervisor should arrange for themselves or another employee to wait with the employee until the PEN arrives. If onsite care is not needed, then accompany the employee to the nearest Florida Hospital CentraCare or Emergency Room as directed by the PEN.

____ If there is ever any question or doubt in regards to immediate treatment of an exposure, do not hesitate to contact the PEN Hotline at any time!

*If employee is not directed to seek medical attention, or does not call the PEN hotline, send email notification of the exposure to Erica Bereczki, HR Analyst and Connie Collins, HR Director, then continue with the Supervisor Checklist for Workers Compensation Claims

CareHere Employee Health & Wellness Center (EHWC)
1-800-423-1330

Monday	8 AM - Noon
Tuesday	8 AM - Noon
Wednesday	1 PM – 5 PM
Thursday	8 AM- Noon
Friday	8 AM- Noon

CentraCare

8010 Red Bug Lake Rd
407-977-3677

Monday	8 AM – 8 PM
Tuesday	8 AM – 8 PM
Wednesday	8 AM – 8 PM
Thursday	8 AM – 8 PM
Friday	8 AM – 8 PM
Saturday	8 AM – 5 PM
Sunday	8 AM – 5 PM

Fire Chief Lars White – Office 407-971-5612 Cell 407-325-1703
Training Division Chief Tim Koepsell – Office 407-971-5614 Cell 407-342-1623

City of Oviedo Employee Infectious Exposure Report Form

General Information

Agency: City of Oviedo Department: _____

Date of Incident: _____ Time of Exposure: _____ AM _____ PM _____

Where Incident Occurred (Address/Location): _____

Employee Information

Employee Name: _____ Title/Position: _____

Address Information: 400 Alexandria Blvd, Oviedo, FL 32765 Phone: 407-971-5524 (Human Resource Dept)

Employee Personal Contact Information: Cell Phone: _____ Other: _____

Employee Emergency Contact Person: Name: _____ Phone: _____

Exposure Information

Bloodborne Fluid Exposure (BBFE): _____ (Blood)

Other Potentially Infectious Material (OPIM): _____ (Spinal, Synovial, Amniotic, Pericardiopleural, Peritoneal, Semen, Vaginal, Tissue, Pus, Feces, Urine)

Non-Other Potentially Infectious Material (Non-OPIM): _____ (Saliva, Tears, Sweat, Vomit, Nasal Secreations, Sputum)

Point of Entry: _____ Puncture _____ Splash _____ Skin Non-Intact _____ Skin In-Tact

_____ Human Bite _____ Airborne _____ Other _____

How Exposure Occurred: _____

PPE in Use at Time of Exposure: _____ Yes _____ Type PPE _____ None Used

Decontamination Actions: _____

Exposure Risk

BBFE or OPIM + Port of Entry = "Significant Exposure"

Non-OPIM + Port of Entry = "Non-Significant Exposure"

(If Non-OPIM fluids contain visible blood or high likelihood of blood present, change to "Significant Exposure"

Source Patient Information

Source Patient Name: _____ Sex: _____ Male _____ Female

Source Patient Physical Address: _____

Source Patient Mailing Address: _____

Source Patient Phone: _____ Cell Phone: _____

Source Patient Primary Care Physician: _____ Phone: _____

Source Patient Transported to Hospital: _____ Yes _____ Hospital _____ No

Source Patient Medical History: _____

_____

Source Patient Medications: _____

_____

Source Patient Known or Reported Infectious Diseases: _____

_____

(Hepatitis A, B, C., Tuberculosis (TB), HIV, AIDS, Meningitis-Viral, Meningitis-Bacterial, Other)

HBV HEPATITIS B VACCINATION PROGRAM

I understand that the City Of Oviedo has offered me the opportunity to acquire the HBV program at no cost to myself if I have not been vaccinated in the last 10 years. Please note, if under 18, this form must be signed by a parent or legal guardian.

At this date and time I have chosen the following option:

- ☐ I have been vaccinated within the last 10 years and I do not wish to receive the vaccination. Complete section 2.
- ☐ I have NOT been vaccinated within the last 10 years and I do not wish to receive the vaccination. Complete Section 2.
- ☐ I have NOT been vaccinated within the last 10 years and I wish to receive the vaccination. Complete Section 1.

Section 1: HBV HEPATITIS B ACCEPTANCE

I agree to accept the HBV screening and will fulfill the necessary and timely obligations to acquire said screening.

I wish to receive the following:

- ☐ Hepatitis B Titer Test
- ☐ Hepatitis B Vaccine Series: 3 shots over a 6 month period with a titer test 1 month after completion.

Name of Employee: _____

Signature: _____ Date: _____

If under 18, parental consent is required.

Parent/Guardian Signature: _____

Section 2: HBV HEPATITIS B DECLINATION

I understand that, due to my occupational exposure to blood and/or potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to me. However, I decline to receive that vaccine at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring the B virus, which is a serious disease. If in the future I continue to have occupational exposure to blood and/or other potentially infectious materials, and I want to be vaccinated, I can receive the vaccination series at no charge to me.

Name of Employee: _____

Signature: _____ Date: _____

If under 18, parental consent is required.

Parent/Guardian Signature: _____