**BLOODBORNE PATHOGEN MEDICIAL SURVELLIANCE DIAGNOSTIC SUMMARY REPORT**

**Examining Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

**Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

**Medical Examination/Additional Comments:**

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

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|  |  |  |  |
| --- | --- | --- | --- |
| **Recommendation** | **Yes** | **No** | **Comments** |
| **Testing:**  |  |  |  |
| Hepatitis B |  |  |  |
|  |  |  |  |
| Hepatitis C |  |  |  |
|  |  |  |  |
| HIV |  |  |  |
|  |  |  |  |
| Blood Cultures |  |  |  |
|  |  |  |  |
| Other |  |  |  |
|  |  |  |  |
| **Specifics:** |  |  |  |
| Future Visits |  |  |  |
| Future Testing |  |  |  |
| Special Intervention |  |  |  |
| Surveillance Program |  |  |  |

**Existing Medical conditions pertinent to bloodborne pathogen exposure:**  \_\_\_\_\_\_

**Employee Statement:**

This is to certify that I have had the results of this examination explained to me, including such testing as the HIV/HBV/HCV test, and I understand what was told to me by the Physician, concerning the results of the evaluations and recommendations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(employee signature)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(physician signature)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(date)**