

Cullman Primary Care, P.C.

EXPOSURE IDENTIFICATION FORM

Name: _____ Date: _____

Job Classification: _____

This form is used to determine your potential exposure levels to bloodborne pathogens. Presume you are not using protective equipment when you review the tasks and procedures you do.

Categories of Workers at Risk:

Examples are:

High Exposure

Physicians, nurses, and all persons
Potentially exposed to pathogens regularly.

Medium Exposure

Housekeeping and x-ray where occasional
Potential exposures once a month or more
might occur.

Low Exposure

Receptionist and business office employees
with no expected contact with exposed
blood products.

Please review the following tasks and procedures. Check the tasks you do. Write in other tasks which are not noted here but which might expose you to blood pathogens.

- Phlebotomy and injections
- Handling blood specimens and other body fluid or tissue specimens
- Procedures involving body orifices such as the mouth or pelvis
- Catheterizations, cauterizations, lacerations
- X-rays of open wounds
- Clean, maintain and sterilize instruments
- Housekeeping and laundry – blood-soaked linens
- Other tasks of potential exposure which you do but are not noted here:

Determination of the Exposure Risk: (check one)

- This employee does not require bloodborne pathogen protection.
- This employee does require bloodborne pathogen protection. The employee has been provided the protective clothing and personal training and has been instructed by seminar.

Date

OSHA Safety Officer



**Cullman Primary Care, P.C.
OSHA Employee Training Contract**

I _____, verify that on _____ my employer provided me with training on the OSHA Regulations. Included in my training were the following items:

1. My rights and responsibilities under the OSH Act
2. General Safety
3. Bloodborne Pathogens: Exposure Risk
4. Hazardous Communications
5. Tuberculosis: TB infection control

I fully comprehend the material presented in this training session, and I understand that my failure to comply with my employer's OSHA policies may result in disciplinary action.

Date: _____ Employee: _____

Safety Coordinator: _____
Donnette Jones, RN, Operations Manager

Cullman Primary Care, PC

EMPLOYEE NON-DISCLOSURE ACKNOWLEDGEMENT

I have been asked by Cullman Primary Care, PC (hereinafter referred to as "the Practice") to reaffirm my commitment made at the time of my employment/assignment to protect the confidentiality of health information. I understand that the Practice reminds its employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue. By my signature below, I acknowledge that I made the commitment set forth below at the time of my employment/assignment, I confirm my past compliance with it, and I reaffirm my continued obligation to it.

The Practice has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my employment/assignment at the Practice, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest of confidence. As a condition of my employment/assignment, I hereby agree that, unless directed by my supervisor, I will not at any time during or after my employment/assignment with the Practice disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my employment/assignment.

When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the patient's care.

I understand that violation of this agreement may result in corrective or disciplinary action, up to and including involuntary discharge.

Employee's Name (Printed)	Date
Employee's Signature	Social Security Number
Witness Printed Name	HIPAA Privacy Training Completion Date: _____
Witness's Signature	