RM0014
Rev. 11/04

BLOODBORNE EXPOSURE INCIDENT REPORT
DECLINATION OF MEDICAL ASSESSMENT TREATMENT

Risk Management Department
Lincoln Public Schools

Employee Name: _____

Social Security Number: _____

Position: _____

Location: _____

Incident Date (mm/dd/yy): _____

Description of Incident:

I hereby decline assessment/treatment for the bloodborne exposure incident noted above. I understand that assessment/treatment by a trained medical provider is recommended by my employer.

_____ _____
Employee Signature *Date*

_____ _____
Health Office Signature *Date*

This form is to be completed when a bloodborne exposure incident has occurred and the employee declines assessment/treatment at the district's designated treatment facility.

SEND COMPLETED FORM TO RISK MANAGEMENT, BOX 14, LPSDO