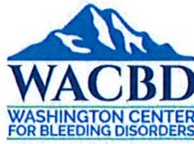


Post Exposure Attestation Form

Date of Injury/Exposure: ________________ Today's Date: __________________

Employee Name: _________________________________ Employee DOB: ___________________

Recommendation:

Employee was encouraged by WACBD to present the injury/exposure to nearest medical treatment facility for proper evaluation and treatment within 24 hours after event.

Body part(s) injured/exposed: ____

Brief description the injury/exposure that took place on date above:

____

____

____

____

I attest I have received and understand the Bloodborne Pathogens (BBP) Policy as part of my employment. I understand it is recommended I seek medical treatment after a work-related injury/exposure. I understand I have the right to decline medical treatment, and if so, will complete the Employee Waiver of Medical Treatment form.

_____________________________ _____________________________

Employee's Name Employee's Signature

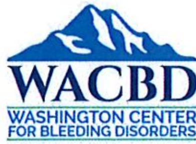
_____________________________ _____________________________

Supervisor's Name Supervisor's Signature

This form has been completed by: _________________________

In the event of supervisor not being present in office, the supervisor can sign the form the following day.

This document can be printed for use. The printed version is not subject to revision control and is for reference only.



Employee Waiver of Medical Treatment

Date of Injury/Exposure: _______________ Today's Date: _________________

Employee Name: ________________________________ Department: __________________

_____ My supervisor did not receive notification of this injury/ incident.
_____ My supervisor did receive notification of this injury/ incident.

Brief description the injury/exposure that took place on date above:

____

____

____

____

Body part(s) injured/exposed:

____

I have been advised of the Washington Center for Bleeding Disorders procedures for seeking medical treatment for my work-related injury/illness. By signing below, I am choosing to decline medical treatment for the above referenced injury. I acknowledge that Washington Center for Bleeding Disorders and my supervisor, in good faith, have offered and made available to me the opportunity to seek necessary medical treatment. I am aware that by declining medical treatment at this time my employer will not be responsible for any medical expenses or lost wages. I understand that I am solely and completely responsible for seeking medical attention on my own and will be solely and completely responsible for any, and all, subsequent bills associated with the decision to decline medical treatment for the above referenced injury. I further understand that my signature on this waiver form may result in the loss of benefits under Washington State's Worker's Compensation Program and/or Washington State Labor and Industries' Compensation Programs.

___________________________ ___________________________
Employee's Name Employee's Signature

___________________________ ___________________________
Supervisor's Name Supervisor's Signature

___________________________ ___________________________
Compliance Officer's Name Compliance Officer's Signature

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