

**Health Care Professional's Written Opinion for Post-Exposure Evaluation**

Employee's Name: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Health Professional's Address: \_\_\_\_\_

\_\_\_\_\_

Health Professional's Telephone: \_\_\_\_\_

\_\_\_\_\_ The employee named above has been informed of the results of the evaluation for exposure to blood or other potentially infectious materials.

\_\_\_\_\_ The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

\_\_\_\_\_ Hepatitis B vaccination is \_\_\_\_\_ is not \_\_\_\_\_ indicated.

\_\_\_\_\_  
Health Care Professional's Name

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

**Return this form to the employer and provide a copy to the employee within 15 days. Please label the outside of the envelope "Confidential."**

Employer's Name \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

Confidential Fax: \_\_\_\_\_