# EMPLOYER'S EXPOSURE INFORMATION FORM

## EXPOSED EMPLOYEE INFORMATION

Employee Name:______________________________

Address:______________________________

City, State, ZIP:______________________________

SSN:______________________ DOB:______________________

Date of Exposure:______________________ Trip/Incident #: ______________________

## EMPLOYER INFORMATION

Employer Name:______________________________

Address:______________________________

City, State, ZIP:______________________________

Phone:______________________ Fax:______________________

Infection Control Contact:______________________________

Phone:______________________ Fax:______________________

Pager:______________________ Email:______________________

## WORKER'S COMPENSATION INFORMATION

Worker's Compensation Plan Name:______________________________

Address:______________________________

City, State, ZIP:______________________________

Phone:______________________ Fax:______________________

Contact Name:______________________________

Phone:______________________ Fax:______________________

Pager:______________________ Email:______________________

## OCCUPATIONAL MEDICAL PROVIDER INFORMATION

Name:______________________________

Address:______________________________

City, State, ZIP:______________________________

Phone:______________________ Fax:______________________

Contact Name:______________________________

Phone:______________________ Fax:______________________

Pager:______________________ Email:______________________