Post-Exposure Form

Student Name: _____ Graduation Year: _____

Date of Exposure: _____ Time of Exposure: _____

Healthcare Facility:

Location within facility:_____ Clinical Rotation:_____

Name of Clinical Supervisor Notified: _____

Date of Notification: _ / / Time of Notification:_____ AM/PM

Clinical Supervisor Notified: □ In person □ Via Phone □ Left Message

Describe specific circumstances of exposure:

Were baseline bloods drawn on student? □ Yes □ No

Were baseline bloods drawn on source patient? □ Yes □ No □ Unknown

Treatment initiated by: □Employee Health □ Emergency Dept. □Clinical Supervisor

Specific treatment that has been initiated on-site:

Comments:

Student Signature_ Date: / /

Please IMMEDIATELY scan and email a copy to Mrs. Cathy Tesoriero at ctesori@nyit.edu and Professor Armand, Director of Clinical Education at yarmand@nyit.edu

Then, please mail the original to: (Keep a copy for your files)
New York Tech/Director of Clinical Education,
Dept. of PA Studies, Riland Center, Suite 352, New York Institute of Technology
101 Northern Boulevard, PO Box 8000, Old Westbury, NY 11568-8000