

CLEVELAND CLINIC HEALTH SYSTEM - EASTERN REGION
CENTER FOR CORPORATE HEALTH
EMERGENCY CARE WORKER (ECW)
EXPOSURE REQUEST FOR INFORMATION

Name _____

Home Address _____

Telephone _____

Employer _____ Department: _____

Employer Address _____

Supervisor's Name _____

Work Telephone _____

Hepatitis B Vaccine Series Completed _____ (year)

Hepatitis B Immunity Titer Positive on _____ (date)

EXPOSURE INFORMATION:

Date of Exposure _____ Time _____

Location _____

Manner of Exposure _____

Substance if known _____

Source Patient Info: Name _____

Date of Birth _____

Transported to _____

Date Received _____

Action _____

Fax to CFCH at: Euclid (216) 692-7549

Hillcrest (440) 312-4181

Huron (216) 761-7950

South Pointe (216) 491-7791

CONFIDENTIAL