COVID-19 Potential Exposure Form

CLEAR PRINT

Your Name:	Your Email Address:	Your Phone Number:

Incident Date:	Incident Number:	Your Role:

Description of PPE Worn:

When was PPE Applied?

- ☐ Prior to Patient Contact
- ☐ During Patient Contact
- ☐ Never

Was the patient provided with a mask?

- ☐ Yes If Yes, What Kind?
- ☐ No

Additional Units / Personnel on Scene:	Role:
1.	
2.	
3.	
4.	
5.	

Brief description of what occurred and why you believe you were exposed

March 24, 2020