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Utah Public Health Laboratory

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Bloodborne Pathogen Exposure
Testing Request Form

Physician Requesting Testing

Name: _____

Office: _____

Address: _____

Phone: _____

Person Exposed

Name: _____

Address: _____

Phone: _____

Type of bodily fluid/sharps producing exposure: _____

Area of body in contact with bodily fluid: _____

Was an open wound exposed: Y N

Address of Occurrence: _____

Date of Exposure: _____ Time of Exposure: _____

Deceased Subject

Name (if known): _____

DOD: _____

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