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Utah Public Health Laboratory

Robyn Atkinson-Dunn, PhD – Director
4431 South 2700 West
Taylorsville, UT
84129-8600

Utah Office of the Medical Examiner

48 North Mario Capecchi Dr.
Salt Lake City, Utah 84113
(801) 584-8410
Fax: (801)-584-8435

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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