



***Form B – Exposure Incident Report Form***  
(To be completed by the student and faculty member or preceptor)

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

INCIDENT:

Student Referred for Medical Services: YES NO (PLEASE CIRCLE)

IF NOT REFERRED, PLEASE EXPLAIN WHY:

Faculty/Preceptor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_