Medical Provider's Written Opinion Form

*The written opinion provided to the exposed individual's supervisor must be limited to those items on this form; all other findings or diagnoses must remain confidential. This information must be provided to the supervisor and exposed individual within **15 days** of completion of the post-exposure evaluation. Please also provide a copy of this form to TWU Risk Management at the address below.*

Name of **Exposed** Individual: _____

Date of exposure incident: _____ Date of initial post-exposure evaluation: _____

Check the following statements as appropriate:

___ The exposed individual **has been informed** of the results of the post-exposure evaluation.

___ The exposed individual **has been informed** of any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Description of any follow-up that is required, including due dates:

_____

Licensed physician/healthcare professional conducting post-exposure evaluation and follow-up:

Name: _____ Telephone: _____

Signature: _____ Date: _____

Address: _____

_____

Please forward a copy of this form to the following address:
Texas Woman's University
Risk Management
Director of Environmental Health & Safety
PO Box 425619
Denton, TX 76204-5619
940-898-2924

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