CONFIRMATION OF ASSESSMENT FOR BLOOD/BODY FLUID EXPOSURE

Instructions for Attending ER/Urgent Care Physician: Please complete this form and provide the original to the Exposed Health Care Worker (EHCW).

Instructions for the Calgary West Central Primary Care Network (CWC PCN) employee or physician member: Please submit the original completed form to the CWC PCN Human Resources department.

I, _____ *(first and last name of attending physician)* confirm that _____ *(first and last name of the EHCW)* was assessed for exposure to blood/body fluids at _____ *(ER or urgent care centre)* on _____ *(dd/mm/yyyy)* in accordance with Calgary West Central Primary Care Network Blood and Body Fluid Exposure protocol.

_____ _____

Attending physician name *(please print)* Attending physician signature