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SAN ANTONIO

UT HEALTH SCIENCE CENTER AT SAN ANTONIO

BLOODBORNE PATHOGEN POST-EXPOSURE TREATMENT MEDICAL RECORD RELEASE FOR UTHSCSA EMPLOYEES

Employee must complete this form in order to apply for reimbursement or initiation of payment to a provider for post-exposure treatment not covered by Workers' Compensation Insurance.

Employee Name: _____
Last Name **First Name**

Employee ID #: _____

Home Address: _____ _____
City **State** **Zip**

Home Phone: _____ **Work Phone:** _____

1. **During the normal course and scope of my duties as an employee at UTHSCSA the exposure incident happened on:** _____
Mo Day Yr
2. **I notified my supervisor :** _____
Last Name **First Name**
On _____ **(immediate supervisor must be notified immediately or as soon as possible following the incident).**
Mo Day Yr

3. **Yes:** ☐ **I have received payments or reimbursements from another entity for this claim.**

No: ☐ **I have not received payments or reimbursements from another entity for this claim.**

The cost of wound care will be billed to the employer's Workers' Compensation Insurance. Other prophylactic treatment costs not covered by Workers' Compensation Insurance may be submitted for payment review to the Environmental Health & Safety Workers' Compensation Coordinator:

Environmental Health & Safety Department, MSC 7928
The University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900
(210) 567-2955; (210) 567-2965 Fax

By signing this form, I agree to release the applicable medical records & billing documentation necessary to complete the application process. These records will be reviewed by Environmental Health & Safety and Accounting, during the process.

Print Name: _____

Employee Signature: _____ **Date:** _____