Policy: Evaluation of Occupational Exposure, Illness, and Injury	**Applicability:** PA Sciences Program Students
Policy Owner: PA Sciences Program	**Approved By:** Dean of the School of Graduate Studies and Research
Effective Date: January 1, 2021	**Last Reviewed:** August 05, 2024
Next Review: August 05, 2025	**Contact:** (615)321-2933

PURPOSE: The purpose of this policy is: To describe the procedures for responding to accidental occupational exposures, illness, or injury.

POLICY: Students who are accidentally exposed to blood and body fluids via needle stick, mucus membranes, or exposure of non-intact skin; or become ill or injured, as the result of a clinical assignment, will be evaluated at the Student Health Center during the Center's normal operating hours. Students must also notify the Office of Student and Academic Affairs of such injury. A reportable event form must be completed in addition to individual affiliate hospital or clinical forms. If the Student Health Center is closed, the student will be referred to Nashville General Hospital Emergency Room or the appropriate medical facility in the community where they are assigned.

DEFINITIONS:
Occupational Exposure – Reasonably anticipated skin, eye, mucus membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

PROCEDURE: Preceding the initial clinical exposure of all students, educational sessions are given which deal with the occupational exposures to infectious and environmental hazards anticipated in the day to day practice of medicine. These sessions are mandatory and cover instruction in the prevention of occupational exposures; procedures for evaluation after exposure; and the effects of infectious and/or environmental disease or disability on student educational activities. The sessions will be given during orientation and are mandatory for any student who rotates to any affiliate hospital or clinical site. Any student who has not completed these sessions will not be allowed to begin or participate in any clinically related activities.
In the event of an exposure, students must notify the Clinical Education Director (by phone, texting or calling), of such injury. A reportable event form must be completed in addition to individual affiliate hospital or clinic forms.

The Student Health Center staff will triage the student and record the following information

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- Student's current immunization status with regard to Hepatitis B and tetanus vaccines and any other pertinent laboratory information;
- Type of injury, when and how the injury occurred, and any pertinent information regarding the patient involved and/or incident.

If the student is located at a distant site, or in cases of dire emergency, the student should first contact the designated administrator at the work site. Any necessary emergency medical and/or nursing care should be made available to the student through the regular procedures in effect at the facility to which the student is assigned. The morning following discharge, the student must report to the Meharry Student Health Center for evaluation ad clearance to return to duty. The student is to bring copies of the discharge instructions and any other information describing the treatment that was rendered. The student will be referred for further follow-up/management if indicated.

Mandatory Blood borne Pathogen / Needle Stick Plan / Airborne Exposure and Procedure:
As members of our medical community, Meharry provides needle stick coverage to all clinical students. You are enrolled in the mandatory pathogen exposure / accident coverage which provides a benefit in case you are exposed to blood or other body fluids through a needle stick or body fluid splash / spill event.

For students who elected the Meharry Medical Insurance Plan, you are covered 100%. In the event of a needle stick:
- Seek treatment from a MMC or participating provider.
- Use your UHC medical plan ID card
- There will be no charge for medical services at point of service.
- If Prescriptions are needed, you will pay applicable copayment and receive reimbursement from UHC.
- Must use UHC participating pharmacy.

For students who declined the Meharry Medical Insurance Plan, you are covered 100% through Star Underwriter. You will be sent an ID card just for this coverage.
- Seek treatment from a MMC or a provider of your choice.

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- Use your medical plan ID card received from Star Underwriter.
- Notify MMC of incident.
- Complete Reimbursement form for STARR
- $12 annual fee.

For a student who becomes tuberculin skin test positive during the course of their medical training due to airborne exposure, they will be evaluated and followed routinely in the Student Health Service without charge. The student must notify the Office of Student and Academic Affairs and the Student Health Services in order for the student to be cleared to return to clinical rotations. The college will assume responsibility for the cost of the initial chest x-ray(s) and such medication as deemed appropriate by Meharry Student Health Service.

EXHIBITS:

STARR

Surplus Lines

Needle Stick Diagnosis and Treatment Claim Form

TO BE COMPLETED BY STUDENTS

1. School Name: Meharry Medical College Policy #: SPR271896

2. Insured Person:_____

3. Local Address: _____

4. Home Address: _____

5. Date of Birth: ____/___/___Local Phone:_____Home Phone:_____

6. Is this claim the result of an accident? Y / N If "yes",

give date of accident:_____ Time of Accident:_____

7. Where did the accident occur?_____

Provide detailed description of the accident and how it occurred. _____

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_____

8. Are you enrolled as a Full Time student in the school' medical or dental college? Y / N

9. Is treatment being provided by the school's medical facility? Y / N

If "no", please identify the provider or providers:

Name of provider: _____

Address: _____

Telephone: ( )_____

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or

Pharmacist to release any information requested with respect to this claim.

It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial or benefits and/or civil damages. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Signature of Insured: _____Date: _____

I hereby certify that the statements made are correct to the best of my knowledge and believe that the above named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on the date of accident.

Signature of College Official:_____ Date: _____

Title _____

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REPORTABLE EVENT FORM

This report and the information contained therein is a privileged communication to the Office of Corporate Compliance and is protected under the Attorney/Client privilege. The Office of Corporate Compliance has authorized the Risk Management Specialist to collect and investigate incidents reported therein. (If you have any questions, call 327-6444).

Please complete this report (in its entirety) in the event of an accident, discovery of a hazardous condition, or any occurrence which is not consistent with routine operation of the institution or routine care of a patient. Submit all forms to Risk Management, Lyttle Hall, 3rd Floor, Room 317, in the Office of Corporate Compliance.

1 NAME _____
ADDRESS _____
_____
PHONE (H) _____ (W) _____
AGE _____ SEX _____

2	EXACT LOCATION OF INCIDENT	BLDG/DEPT	FLOOR	ROOM NO.	DATE	TIME AM PM
	DISCOVERED BY		TITLE			

3 INCIDENT
__ 1E Slip/Fall
__ 2E Medication
__ 3E Injury
__ 4E Equipment
__ 5E Procedures
__ 6E Elopement/AMA
__ 7E Sharp Instr. Injury
__ 8E Theft/Break-In
__ 9E Auto Accident
__ Fire/Flood
__ Evacuation
__ Other

CONCISE DESCRIPTION OF OCCURRENCE (STATE SIGNIFICANT FACTS IN CHRONOLOGICAL ORDER, I.E., INCLUDE SPECIFIC ENTRANCE/EXIT OR CONDITION SURROUNDING INCIDENT)

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4 WITNESSES	NAME	HOME ADDRESS	TELEPHONE NO.
	NAME	HOME ADDRESS	TELEPHONE NO.
5 BACKGROUND Inpatient Outpatient	PATIENT'S DIAGNOSIS		ADMISSION DATE
	SURGICAL PROCEDURE/OUTPATIENT TREATMENT		
	Medication Within Past 8 Hours: Yes / No	NAME OF MEDICATION	SEDATIVE LAXATIVE DURETIC OTHER
6 Visitor Employee Student Other	REASON FOR BEING AT FACILITY		
	Department	Title	On Duty: YES / NO
7 Treatment	Was There an Injury? Yes No	Patient/Family Aware of Incident? Yes No	Was Examination or Treatment Refused? Yes No
	Attending Physician Notified? Yes No – If Yes, Date _____ Time _____ AM PM		Injured Person's Signature, If Yes
	X-Ray Ordered Yes No Results (If Known) _____		
	Diagnosis and Recommendation _____		
	_____ SIGNATURE _____ MD		
8a REPORTING	EMPLOYEE MUST REPORT INCIDENT TO SUPERVISOR. STUDENT MUST REPORT INCIDENT TO THE DEAN OF STUDENT AFFAIRS. VISITOR MUST CALL THE DEPARTMENT OF PUBLIC SAFETY AT 327-6666.		
8b FOLLOW-UP	INVESTIGATION REPORT WILL BE COMPLETED BY RISK MANAGEMENT.		
9a	TYPE OR PRINT NAME OF PERSON COMPLETING THIS REPORT		
9b	SIGNATURE OF PERSON COMPLETING THIS REPORT	TITLE	DATE

This report is for data analysis and loss control purposes only. It is not to be construed as notification to the insurance company of possible claim.