

# Exposure to Infectious and Environmental Hazards Policies and Procedures

PA-KNOXVILLE  
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## **LMU STUDENT POLICIES AND PROCEDURES**

All PA Students must comply with LMU student policies and procedures published in the LMU Student Handbook which can be accessed electronically (<https://www.lmunet.edu/student-life/documents/Handbook%2019-20%209.6.3.pdf>).

### **PA PROGRAM STUDENT POLICIES AND PROCEDURES**

Program policies and procedures apply to all students whether on campus or off campus at a Clinical Site. The policies and procedures of Clinical Affiliates who provide SCPEs may supersede the Program's policies and procedures (A3.01). Policies and procedures published in this handbook are reviewed each year prior to the start of a new student cohort. Students may access this handbook electronically on the Program's online learning management system. The Program Director provides matriculating students with an overview of the Program policies and procedures during orientation in the first semester (A3.02). Changes to Program policies and/or procedures are communicated with students via University-issued student email accounts. These changes are also published in this handbook (A3.02).

### **EXPOSURE TO INFECTIOUS AND ENVIRONMENTAL HAZARDS CLAIMS PROCEDURE**

Detailed information on the prevention and treatment of exposure to blood borne pathogens is contained in the CDC brochure, "Exposure to Blood: what Healthcare Personnel Need to Know" (<http://stacks.cdc.gov/view/cdc/6853/>).

If a student experiences a needle stick, sharps injury, or is otherwise exposed to the blood of a patient while participating in activities directly related to the curriculum, the student should:

- Immediately perform basic first aid. Wash needle sticks and cuts with soap and water. Flush splashes to the nose, mouth, or skin with water. For ocular exposures, flush eyes with water, normal saline solution, or sterile irrigates for several minutes.
- Immediately report the incident to the Director of Didactic Education during the Didactic Phase of training or to the clinical preceptor and Director of Clinical Education during the Clinical Phase of training. Prompt reporting is essential. In some cases, post exposure treatment may be recommended and should be started as soon as possible. If there is a potential exposure to Human Immunodeficiency Virus (HIV), it is imperative to initiate post exposure prophylaxis (PEP) within two hours of the incident. Also, without prompt reporting, the source patient may be released before testing for infectious diseases can be conducted.
- Seek post exposure services. During the Didactic Phase, students will be referred to the emergency department of the closest hospitals. The hospital will file claims with the health insurance company; however, students are responsible for payments not covered by their health insurance provider. UMC clinic locations include 165 Westmoreland Street, Harrogate, TN and 424 N. Broad Street, New Tazewell, TN. Call 423-869-7193 to schedule an appointment. There are two hospitals in the immediate vicinity, Parkwest Medical Center, 9352 Park West Blvd., Knoxville, TN 37932 and Turkey Creek Medical Center, 10820 Parkside Drive, Knoxville, TN 37932. Both hospitals have emergency

services 24 hours a day, seven days a week. Hospital care is not included with tuition; therefore, students are responsible for the cost of services rendered. Students may follow-up on post-exposure care with Internal Medicine Associates, 7744 Conner Road, Powell, TN 37849.

- File the claim with your personal health insurance company as the primary insurance. Do not file as a worker's compensation claim. File the claim with First Agency, Inc. as your secondary insurance. Fees and copays are paid through First Agency.  
First Agency, Inc.  
5071 West H Avenue  
Kalamazoo, MI 4009-8501  
Phone (269)381-6630  
Fax (269) 381-3055
- Complete the following documents in the "Post Exposure Documents Packet" and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the Clinical Administrative Assistant during the Clinical Phase of training: Student Accident Claim, Authorization to Permit Use and Disclosure of Health Information, Parent/Guardian/Student Information, and Incident Form.
- Copy the front and back of your health insurance card and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the Clinical Administrative Assistant during the Clinical Phase of training.
- Collect all itemized bills for medical expenses associated with the injury that have not been paid (itemized bills include the date of service, procedure code and diagnosis code – not balance due statements) including all worksheets, denials, and/or statements of benefits from your primary insurer (each charge must be processed by your primary insurance before those charges can be processed by First Agency, Inc.) and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the Clinical Administrative Assistant during the Clinical Phase of training.
- Collect a UB-04 or HCFA billing statement related to the injury from the billing office of the clinical site during the Clinical Phase of training and submit to the Assistant Clinical Coordinator.
- The LMU-Knoxville PA Program will submit all completed documents to First Agency, Inc.

### **BLOOD BORNE PATHOGENS and LATEX ALLERGY POLICIES**

Bloodborne Infectious Diseases: Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV)

<https://www.cdc.gov/niosh/topics/bbp/default.html>

## **Human Immunodeficiency Virus (HIV)**

Human Immunodeficiency Virus (HIV) is a blood-borne virus typically transmitted through sexual intercourse, shared intravenous drug needles, and mother-to-child transmission during the birth process or breast feeding. HIV disease is caused by infection with HIV-1 or HIV-2 retroviruses that attack the host's immune system, most specifically the CD4 cells. Co-infection with other viruses that share similar routes of transmission (HBV, HCV, HHV8) is common.

Acute seroconversion (the time period during which a specific antibody develops and becomes detectable in the blood) manifests as a flulike illness (fever, malaise, generalized rash) and may be associated with generalized lymphadenopathy. This occurs within two to four weeks after infection with HIV. People with acute seroconversion have a large amount of HIV in their blood (high viral load) and are very contagious. However, some people may not develop symptoms. Following acute seroconversion is a period of clinical latency where the HIV is still active but reproduces at much lower levels. This stage may last for years and may not cause any symptoms. AIDS is the most severe stage of HIV infection. In this stage, the immune system is severely impaired (CD4 cell count drops below 200 cells/mm) allowing for the development of opportunistic illnesses. Without treatment, people with AIDS typically survive about three years. Common symptoms of AIDS include fever, chills, sweats, malaise, generalized lymphadenopathy, and weight loss. Their viral load is high and they are very contagious.

Healthcare workers can acquire HIV infection through occupational exposures. As of December 31, 2013, there were 58 confirmed occupational transmissions of HIV and 150 possible transmissions reported in the United States. Of these, only one confirmed case has been reported since 1999. The risk of a healthcare worker becoming infected with HIV after being exposed to a needle stick contaminated with HIV-infected blood at work is 0.23%. Risk of exposure due to splashes with even overtly bloody contaminated body fluids is thought to be near zero.

It is the policy of the LMU-Knoxville PA Program to follow CDC and OSHA guidelines to prevent transmission of HIV in the healthcare setting. Program students, faculty, and staff members are to follow standard precautions and assume that all blood or body fluids are potentially infectious. These guidelines include the following:

- Routine use of personal protective equipment (such as gloves, face and eye shields, and gowns) when anticipating contact with blood or body fluids.
- Immediate washing of hands and other skin surfaces after contact with blood or body fluids.
- Careful handling and disposal of sharp instruments during and after use.
- Careful use of safety devices developed to help prevent needle stick injuries.

Any LMU-Knoxville PA Program student, faculty, or staff member with an occupational exposure is required to seek medical attention immediately as post exposure prophylaxis (PEP) with antiretroviral therapy (ART) is more effective the sooner it is initiated after exposure. Most PEP regimens follow a four-week, two-drug regimen initiated as soon as possible after exposure (within 72 hours). A three-drug regimen may be required for HIV exposures that pose an increased risk of transmission.

To date, there is no cure for HIV and AIDS and there is no vaccine to prevent HIV or AIDS.  
Occupational HIV Transmission and Prevention among Health Care Workers  
CDC June 2015

<https://www.cdc.gov/hiv/pdf/workplace/cdc-hiv-healthcareworkers.pdf>

### **Hepatitis B Virus (HBV)**

Hepatitis B virus (HBV) is a hepadnavirus that invades hepatocytes. The interaction of the virus with the host immune system leads to liver injury and, potentially, cirrhosis and hepatocellular carcinoma. Infected people can experience an acute symptomatic phase (usually about 90 days after exposure to HBV) including fever, myalgia, malaise, anorexia, nausea, vomiting, jaundice, and right upper quadrant pain or they may be asymptomatic. Patients with chronic active hepatitis, especially during the replicative state, may have symptoms similar to the acute symptomatic phase.

Sexual contact, needle sticks, needle sharing blood transfusions, and organ transplantations are routes for HBV transmission. Blood contains the highest HBV titers of all body fluids and is the most important vehicle of transmission in the healthcare setting. HBV is highly resistant to extremes of temperature and humidity and can survive in dried blood at room temperature on environmental surfaces for at least one week. HBsAg can be found in other body fluids, including breast milk, bile, cerebrospinal fluid, feces, nasopharyngeal washings, saliva, semen, sweat, and synovial fluid.

HBV is the most efficiently transmissible of the blood-borne viruses important in healthcare settings. The risk of HBV infection is primarily related to the degree of contact with blood and the HBeAg status of the source patient. In studies of healthcare workers who sustained injuries from needles contaminated with blood containing HBV, the risk of developing clinical hepatitis if the blood was both HBsAg positive and HBeAg positive was up to 31%. By comparison, the risk of developing clinical hepatitis if the blood was HBsAg positive and HBeAg negative was up to 6%.

Before widespread implementation of HepB vaccination, HBV infection was a common occupational risk among healthcare workers. The use of standard precautions and routine HepB vaccination of healthcare workers have resulted in a 98% decline in HBV infections from 1983 through 2010 among healthcare workers.

It is the policy of the LMU-Knoxville PA Program to follow CDC and OSHA guidelines to prevent transmission of HBV in the healthcare setting. Program students, faculty, and staff members are to follow standard precautions and assume that all blood or body fluids are potentially infectious. These guidelines include the following:

- Routine use of personal protective equipment (such as gloves, face and eye shields, and gowns) when anticipating contact with blood or body fluids.
- Immediate washing of hands and other skin surfaces after contact with blood or body fluids.
- Careful handling and disposal of sharp instruments during and after use.
- Careful use of safety devices developed to help prevent needle stick injuries.

OSHA mandates that healthcare workers who have a reasonable expectation of occupational exposure to blood or body fluids be offered the hepatitis B vaccine (Bloodborne Pathogens Standard [29 CFR 1910.1030 and 29 CFR 1910.030f]). Approximately 25% or more of medical and dental students and many physicians, surgeons, and dentists in the United States have been born to mothers in or from countries in Asia (including India), Africa, and the Middle East with high and intermediate endemicity for HBV. The CDC recommends that all healthcare providers at risk for HBV infection be tested and that all those found to be susceptible should receive the vaccine.

The three-dose HepB vaccine series produces a protective antibody response (anti-HBs > 10 ml/U/mL) in > 90% of healthy adults < 40 years-old. Factors such as smoking, obesity, aging, chronic medical conditions, drug use, diabetes, male sex, genetic factors, and immune suppression contribute to a decreased response to the HepB vaccine.

All LMU-Knoxville PA Students are required to complete the HepB vaccine series. Students must provide proof of initial vaccination in the HepB vaccine series (or if the series is already completed, then proof of immunity with a qualitative or quantitative anti-HBs titer) prior to matriculation and proof of immunity (with a qualitative or quantitative anti-HBs titer) prior to clinical rotations.

Any LMU-Knoxville PA Program student, faculty, or staff member with an occupational exposure is required to seek medical attention immediately to prevent delays in treatment. The management of a healthcare worker with an occupational exposure to HBV depends on the anti-HBs status of the healthcare worker and the HBsAg status of the source patient. The healthcare worker should be tested for anti-HBs and the source patient (if known) should be tested for HBsAg as soon as possible after the exposure. More detailed management recommendations are listed in “Table 1. Post-exposure management of healthcare personnel after occupational percutaneous and mucosal exposure to blood and body fluids, by healthcare personnel HepB vaccination and response status”.

**TABLE 1. Post-exposure management of healthcare personnel after occupational percutaneous and mucosal exposure to blood and body fluids, by healthcare personnel HepB vaccination and response status**

Healthcare personnel status	Postexposure testing		Postexposure prophylaxis		Postvaccination serologic testing <sup>†</sup>
	Source patient (HBsAg)	HCP testing (anti-HBs)	HBIG*	Vaccination	
Documented responder <sup>§</sup> after complete series (≥3 doses)	No action needed				
Documented nonresponder <sup>¶</sup> after 6 doses	Positive/unknown	—**	HBIG x2 separated by 1 month	—	No
	Negative	No action needed			
Response unknown after 3 doses	Positive/unknown	<10mIU/mL**	HBIG x1	Initiate revaccination	Yes
	Negative	<10mIU/mL	None		
	Any result	≥10mIU/mL	No action needed		
Unvaccinated/incompletely vaccinated or vaccine refusers	Positive/unknown	—**	HBIG x1	Complete vaccination	Yes
	Negative	—	None	Complete vaccination	Yes

\* HBIG should be administered intramuscularly as soon as possible after exposure when indicated. The effectiveness of HBIG when administered >7 days after percutaneous, mucosal, or nonintact skin exposures is unknown. HBIG dosage is 0.06 mL/kg.

† Should be performed 1–2 months after the last dose of the HepB vaccine series (and 4–6 months after administration of HBIG to avoid detection of passively administered anti-HBs) using a quantitative method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL).

§ A responder is defined as a person with anti-HBs ≥10 mIU/mL after ≥3 doses of HepB vaccine.

¶ A nonresponder is defined as a person with anti-HBs <10 mIU/mL after ≥6 doses of HepB vaccine.

\*\* HCP who have anti-HBs <10mIU/mL, or who are un-vaccinated or incompletely vaccinated, and sustain an exposure to a source patient who is HBsAg-positive or has unknown HBsAg status, should undergo baseline testing for HBV infection as soon as possible after exposure, and follow-up testing approximately 6 months later. Initial baseline tests consist of total anti-HBc; testing at approximately 6 months consists of HBsAg and total anti-HBc.

**ABBREVIATIONS**

HCP = healthcare personnel  
 HBsAg = hepatitis B surface antigen  
 anti-HBs = antibody to hepatitis B surface antigen  
 HBIG = hepatitis B immune globulin

Adapted from *CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management*, MMWR 2013; 62(RR10): 1–19; [www.cdc.gov/mmwr/pdf/rr/rr6210.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf).

Hepatitis B and Healthcare Personnel

CDC

<http://www.immunize.org/catg.d/p2109.pdf>

Morbidity and Mortality Weekly Report (MMWR): Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices  
 CDC January 12, 2018

<https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm>

## **Hepatitis C Virus (HCV)**

Hepatitis C virus (HCV) is an RNA virus that invades hepatocytes leading to inflammation and possibly cirrhosis and hepatocellular carcinoma. Symptoms of acute HCV infection, such as arthralgias, myalgias, pruritis, paresthesias, can occur within six months after exposure to HCV. Most people with acute HCV infection develop chronic HCV infection.

Transfusion of blood contaminated with HCV was the leading mode of transmission prior to screening of donated blood for HCV antibody beginning in 1992. More advanced screening tests for HCV have reduced the risk of HCV transmission through blood transfusion to less than one per two million units transfused. People who inject illicit drugs with nonsterile needles are at the highest risk for HCV infection. HCV may also be transmitted via sexual contact, tattooing, sharing razors, and acupuncture. HCV transmission may occur during the birth process but breastfeeding is not associated with HCV transmission.

Healthcare workers can acquire HCV infection through needle stick injuries or other occupational exposures. Needle stick injuries in the healthcare setting result in a 3% risk of HCV transmission.

It is the policy of the LMU-Knoxville PA Program to follow CDC and OSHA guidelines to prevent transmission of HCV in the healthcare setting. Program students, faculty, and staff members are to follow standard precautions and assume that all blood or body fluids are potentially infectious. These guidelines include the following:

- Routine use of personal protective equipment (such as gloves, face and eye shields, and gowns) when anticipating contact with blood or body fluids.
- Immediate washing of hands and other skin surfaces after contact with blood or body fluids.
- Careful handling and disposal of sharp instruments during and after use.
- Careful use of safety devices developed to help prevent needle stick injuries.

Any LMU-Knoxville PA Program student, faculty, or staff member with an occupational exposure is required to seek medical attention immediately to prevent delays in treatment. HCV can be detected in blood within one to three weeks after exposure. There is currently no vaccine to prevent HCV. Any LMU-Knoxville PA Program student, faculty, or staff member with an occupational exposure is required to seek medical attention immediately to prevent delays in treatment. Treatment of acute HCV can reduce the risk of progression to chronic HCV. Recommendations for pharmacologic therapy vary and management by a specialist is recommended.

Viral Hepatitis: Hepatitis C FAQs for Health Professionals

CDC February 23, 2018

<https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>

### **Hepatitis D Virus (HDV)**

HDV also infects hepatocytes but is uncommon in the United States. HDV infection only occurs among people who are infected with HBV because HDV is an incomplete virus that requires the helper function of HBV to replicate. HDV can be transmitted via percutaneous or mucosal contact with HDV-infected blood. Any LMU-Knoxville PA Program student, faculty, or staff member with an occupational exposure is required to seek medical attention immediately to prevent delays in treatment. There is no vaccine for HDV but HepB vaccination can prevent HDV infection.

Viral Hepatitis: Hepatitis D

CDC December 18, 2015

<https://www.cdc.gov/hepatitis/hdv/>

### **Less Common Bloodborne Pathogens**

Students may be exposed to blood borne pathogens that cause the following conditions during the course of their training: Syphilis, Malaria, Babesiosis, Brucellosis, Leptospirosis, Arboviral infections (including Colorado Tick Fever), Relapsing Fever, Creutzfeldt-Jakob Disease, Human T-lymphotropic Virus Type I, and Viral Hemorrhagic Fever.

### **Latex Allergy**

Latex refers to the natural rubber latex manufactured from a milky fluid that is primarily obtained from the rubber tree. The U.S. Food and Drug Administration (FDA) requires labeling of medical devices that contain natural rubber latex. Some synthetic materials referred to as “latex” do not contain the natural rubber proteins responsible for latex allergy symptoms. Healthcare workers are at risk of developing latex allergy because of the frequent use of latex gloves. Latex proteins also become fastened to the lubricant powder used in some gloves; therefore, when healthcare workers change gloves, the protein/powder particles become airborne and can be inhaled.

The most common reaction to latex products is irritant contact dermatitis. Other symptoms of latex allergy include itchy eyes, rhinorrhea, sore throat, respiratory symptoms, and rarely, shock. The prevalence of latex allergy in healthcare workers is 8-12% (compared to 1-6% of the general population).

Appropriate barrier protection is necessary when exposure to blood borne pathogens or other infectious agents is anticipated. The use of powder-free gloves with reduced protein content will reduce exposure, and subsequent sensitization, to latex. After removing latex gloves, wash hands with mild soap and dry thoroughly. “Hypoallergenic” latex gloves do not reduce the risk of latex allergy but they may reduce reactions to the chemical additives in the latex. Any LMU-Knoxville PA Program student, faculty, or staff member with a suspected allergic reaction to latex is required to seek medical attention immediately to prevent delays in treatment.

Latex Allergy: A Prevention Guide

CDC June 6, 2014

<https://www.cdc.gov/niosh/docs/98-113/>

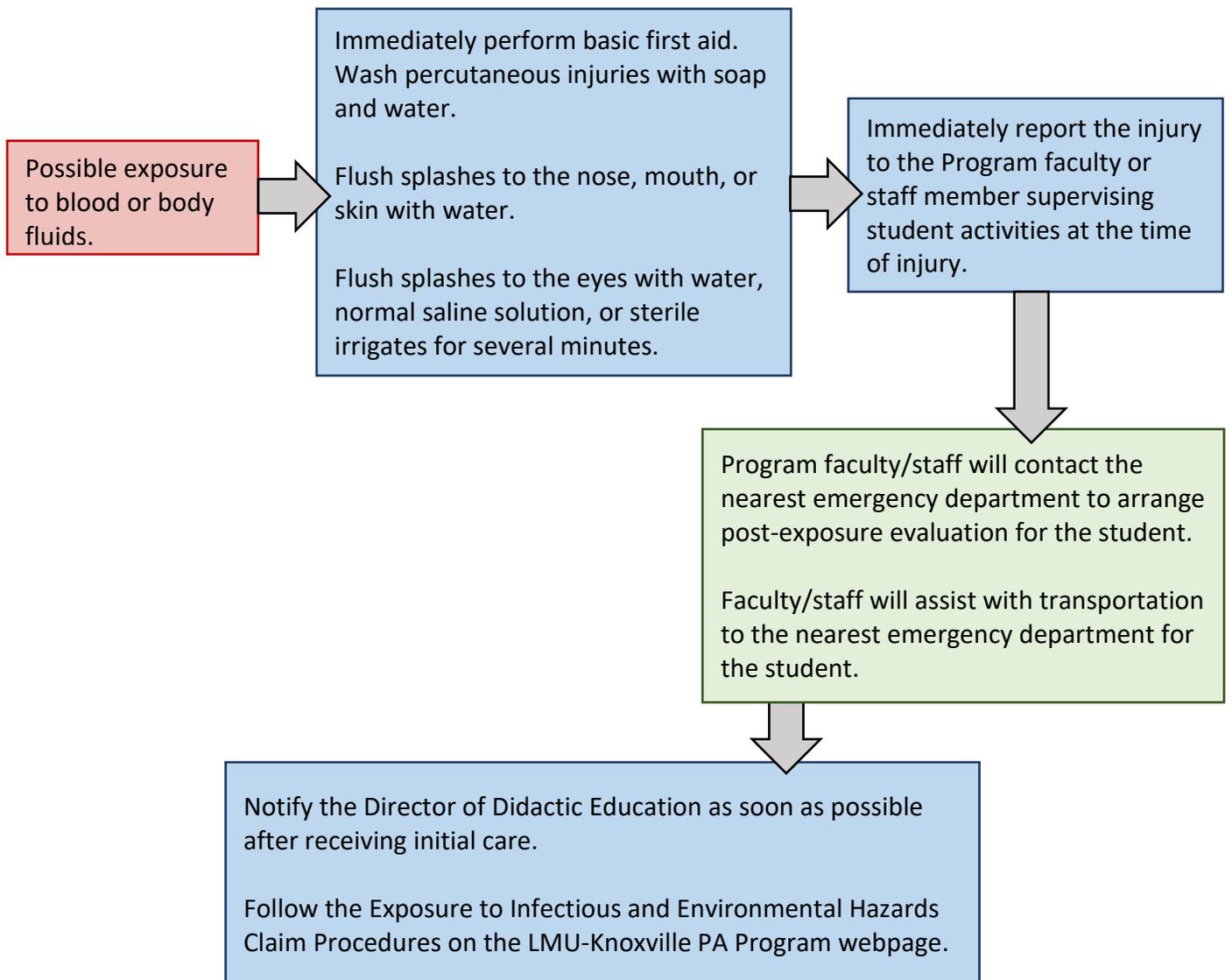
NIOSH Alert: Preventing Allergic Reactions to Natural Rubber Latex in the Workplace  
NIOSH August 1998  
<https://www.cdc.gov/niosh/docs/97-135/pdfs/97-135.pdf>

**Percutaneous Injuries and Blood Borne Pathogen Exposure Procedures  
during Didactic Phase**  
(A3.08)

All students, faculty, and staff must adhere to routine use of personal protective equipment (PPE), such as gloves, face and eye shields, and gowns when anticipating contact with blood or body fluids.

All students, faculty, and staff must adhere to careful handling and proper disposal of sharp instruments during and after use.

All students, faculty, and staff must adhere to careful use of safety devices developed to help prevent percutaneous injuries.

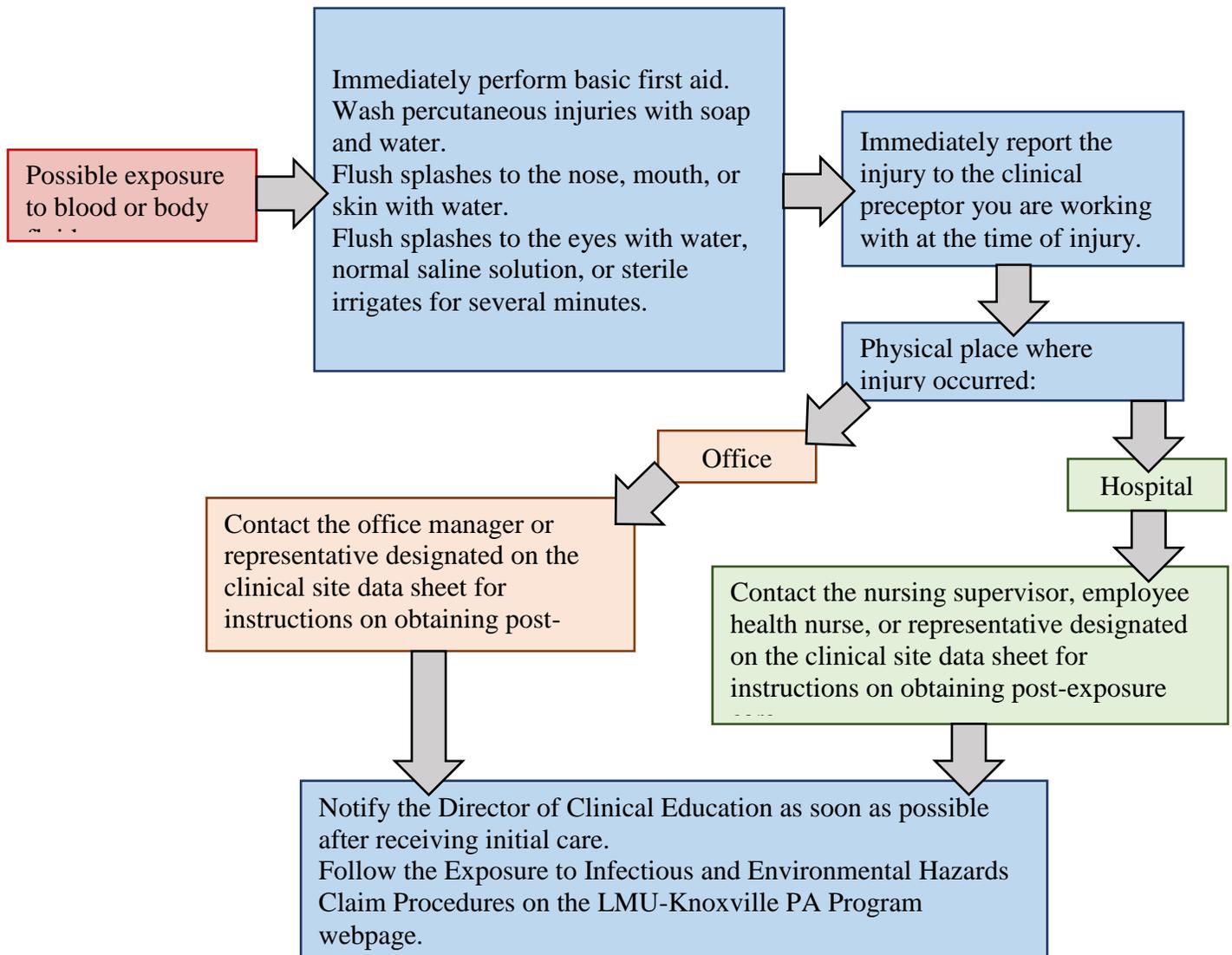


Students must report incidents promptly to the Program to avoid issues that may arise with payment for post-exposure treatment later. Students must file all medical claims with their personal health insurance provider first.

## Percutaneous Injuries and Blood Borne Pathogen Exposure Procedures during SCPEs

(A3.08)

All students, faculty, and staff must adhere to routine use of personal protective equipment (PPE), such as gloves, face and eye shields, and gowns when anticipating contact with blood or body fluids. All students, faculty, and staff must adhere to careful handling and proper disposal of sharp instruments during and after use. All students, faculty, and staff must adhere to careful use of safety devices developed to help prevent percutaneous injuries.



Students must report incidents promptly to the Program to avoid issues that may arise with payment for post-exposure treatment later. Some Clinical Affiliates provide post-exposure treatment at no cost to students. Students must file all medical claims with their personal health insurance provider first.

## **EXPOSURE TO INFECTIOUS AND ENVIRONMENTAL HAZARDS CLAIMS PROCEDURE**

Detailed information on the prevention and treatment of exposure to blood borne pathogens is contained in the CDC brochure, “Exposure to Blood: what Healthcare Personnel Need to Know” (<http://stacks.cdc.gov/view/cdc/6853/>).

If a student experiences a needle stick, sharps injury, or is otherwise exposed to the blood of a patient while participating in activities directly related to the curriculum, the student should:

- Immediately perform basic first aid. Wash needle sticks and cuts with soap and water. Flush splashes to the nose, mouth, or skin with water. For ocular exposures, flush eyes with water, normal saline solution, or sterile irrigates for several minutes.
- Immediately report the incident to the Director of Didactic Education during the Didactic Phase of training or to the clinical preceptor and Director of Clinical Education during the Clinical Phase of training. Prompt reporting is essential. In some cases, post exposure treatment may be recommended and should be started as soon as possible. If there is a potential exposure to Human Immunodeficiency Virus (HIV), it is imperative to initiate post exposure prophylaxis (PEP) within two hours of the incident. Also, without prompt reporting, the source patient may be released before testing for infectious diseases can be conducted.
- Seek post exposure services. During the Didactic Phase, students will be referred to the emergency department of the closest hospitals. The hospital will file claims with the health insurance company; however, students are responsible for payments not covered by their health insurance provider. UMC clinic locations include 165 Westmoreland Street, Harrogate, TN and 424 N. Broad Street, New Tazewell, TN. Call 423-869-7193 to schedule an appointment. There are two hospitals in the immediate vicinity, Parkwest Medical Center, 9352 Park West Blvd., Knoxville, TN 37932 and Turkey Creek Medical Center, 10820 Parkside Drive, Knoxville, TN 37932. Both hospitals have emergency services 24 hours a day, seven days a week. Hospital care is not included with tuition; therefore, students are responsible for the cost of services rendered. Students may follow-up on post-exposure care with Internal Medicine Associates, 7744 Conner Road, Powell, TN 37849.
- File the claim with your personal health insurance company as the primary insurance. Do not file as a worker’s compensation claim. File the claim with First Agency, Inc. as your secondary insurance. Fees and copays are paid through First Agency.  
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5071 West H Avenue  
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- Complete the following documents in the “Post Exposure Documents Packet” and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the

Clinical Administrative Assistant during the Clinical Phase of training: Student Accident Claim, Authorization to Permit Use and Disclosure of Health Information, Parent/Guardian/Student Information, and Incident Form.

- Copy the front and back of your health insurance card and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the Clinical Administrative Assistant during the Clinical Phase of training.
- Collect all itemized bills for medical expenses associated with the injury that have not been paid (itemized bills include the date of service, procedure code and diagnosis code – not balance due statements) including all worksheets, denials, and/or statements of benefits from your primary insurer (each charge must be processed by your primary insurance before those charges can be processed by First Agency, Inc.) and submit to the Didactic Administrative Assistant during the Didactic Phase of training or to the Clinical Administrative Assistant during the Clinical Phase of training.
- Collect a UB-04 or HCFA billing statement related to the injury from the billing office of the clinical site during the Clinical Phase of training and submit to the Assistant Clinical Coordinator.
- The LMU-Knoxville PA Program will submit all completed documents to First Agency, Inc.