

PARTICIPANTS MUST COMPLETE AND SUBMIT TO THE DIOCESAN SCHOOL OFFICE

BLOODBORNE PATHOGENS EDUCATION AND TRAINING

Employee's Name _____

Social Security Number _____

Employer's Name _____

Employer's Address _____

Position _____

I attended the Bloodborne Pathogens Education and Training Class on _____
(Date)

At _____
(Place)

Employee's Signature: _____

Date: _____