INTERIM EXPOSURE CONTROL PLAN
OAK RIDGE NATIONAL LABORATORY (ORNL)
BLOODBORNE PATHOGENS PROGRAM

TRAINING RECORD OF COMPLETION

Name:_____ Badge Number:_____

Phone Number:_____ Email Address:_____

Signature:_____ Date:_____

By submitting my record of completion for this training, I agree that I have read the applicable material. Questions or concerns I may have had in regard to the contents of this training have been answered either through additional review or contact with my supervisor.

Instructions: Complete this form after completing the training and review of the of the Interim Exposure Control Plan for the ORNL Bloodborne Pathogens Program. Send completed forms to J.L. Johnson (Phone: 576-5084, Internal Mailing address is Building 3047A, Room 329, MS-6023) to receive credit for this training.