NATIONAL UNIVERSITY OF Natural Medicine
HEALTH CENTERS

Form B

Source Individual/Patient
CONSENT FOR LABORATORY TESTING

Bloodborne Pathogen Post-Exposure

I have been informed that during the performance of their duties, an employee/student of NUNM was exposed to a bodily fluid of mine. In order to assess and minimize the risks associated with this exposure, I (*please initial the statement that best applies)*

Do_____ Do NOT _____

give consent for a sample of my blood to be drawn by a licensed laboratory or healthcare provider to detect the presence of infectious organisms including Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV). I have been advised of the side effects of a blood draw.
I understand that the tests will be conducted in a confidential manner so as to protect my identity. I also understand that if not covered by my medical insurance, NUNM will reimburse me for any cost of testing.

Results may be made available to my personal physician (if noted below), the exposed employee/student of NUNM, their treating healthcare provider, and to the NUNM Safety Committee in order to comply with state and federal regulations.

_____
Physician Name

_____
_____
_____ _____
Physician Address Physician Phone Number

_____ _____
Print Source Individual's Name Phone Number

_____ _____
Signature Date

_____ _____
Print Witness Name

_____ _____
Witness Signature Date