nunm HEALTH CENTERS NATIONAL UNIVERSITY OF Natural Medicine

Form C

Exposed Individual
CONSENT FOR LABORATORY TESTING

Bloodborne Pathogen Post-Exposure

On_____, I was inadvertently exposed to a potentially infectious bodily fluid. In order to assess and minimize the risks associated with this exposure, I *(initial below)*

Do_____ Do NOT_____

give my consent for a small amount of blood to be drawn from me to detect the presence of disease including Hepatitis B Virus, Hepatitis C and HIV. I have been advised of the side effects of a blood draw. I also understand that the tests will be conducted in a confidential manner by a licensed laboratory 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) and the NUNM Safety Committee in order to comply with state and federal regulations.

_____
Physician Name

_____
_____
_____ _____
Physician Address Physician Phone Number

_____ _____
Print Exposed Individual's Name Phone Number

_____ _____
Exposed Individual's Signature Date

_____ _____
Print Witness Name

_____ _____
Witness Signature Date