

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