NATIONAL UNIVERSITY OF Natural Medicine
HEALTH CENTERS

Form E

MEDICAL EVALUATION FORM

Bloodborne Pathogen Post-Exposure

On_____(date), I was involved in an exposure incident involving potentially infectious bodily fluids.

By initialing next to <u>each</u> of the following, I acknowledge;

_____That I have informed my health center supervisor and the NUNM Medical Director Office at the National University of Natural Medicine (NUNM) Clinic of the details of my exposure incident in writing;

_____That NUNM has made available to me the option to pursue confidential blood testing and post exposure treatment via 1) a *limited* medical evaluation through NUNM's Medical Director Office, OR 2) a *full* medical evaluation provided by a licensed health care professional of my choice;

_____That NUNM has also offered to confidentially identify and test the source individual, where feasible and permitted by law;

_____ That I will be made aware of the results of testing of the source individual, where feasible and permitted by law

_____ That I am fully aware of risk of disease transmission involved in the performance of my duties, and I have been provided with training and education at NUNM concerning these hazards.

By initialing next to <u>ONE</u> of the following, I acknowledge;

_____that I voluntarily DECLINE to participate in a <u>limited OR full</u> medical evaluation at this time, but may elect to have an evaluation at a later date.

_____that I voluntarily CONSENT to participate in a <u>limited</u> medical evaluation (including blood testing and/or PEP therapy, as recommended by NUNM's Medical Director Office);

_____that I voluntarily CONSENT to participate in a <u>full</u> medical evaluation to be completed by a physician of my choice.

Student, Patient, or Employee Printed Name:_____

Student, Patient, or Employee Signature:_____ **Date:**_____

Witness/NUNM Representative:_____ **Date:**_____