NATIONAL UNIVERSITY OF Natural Medicine
HEALTH CENTERS

Form E

MEDICAL EVALUATION REFUSAL FORM

Bloodborne Pathogen Post-Exposure

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

_____
_____
_____
_____

By initialing next to each of the following, I acknowledge:

_____That I have informed my health center supervisor (for students) 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 confidential medical evaluation and follow-up, provided by a licensed health care professional;

_____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 a medical evaluation and treatment could include post-exposure prophylaxis,when medically indicated, if I so desire;

_____ That the medical evaluation and treatment includes expert medical advice, evaluation of reported illnesses and counseling;

_____ I understand that I may elect to have the evaluation at a later date.

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.
Nevertheless, I voluntarily decline to participate in a full medical evaluation.

Student, Patient, or Employee Printed Name:_____

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

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

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