Form B

Source Individual/Patient
CONSENT FOR LABORATORY TESTING

Bloodborne Pathogen Post-Exposure

I have been informed that during the performance of his/her duties, an employee/student of NUNM was exposed to a bodily fluid of mine. In order to asses and minimize the risk to the exposed individual, I

Do _____ Do NOT _____

give consent for a sample of my blood to be tested by a licensed laboratory 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 this test will not be charged to me.

Results of the blood draw will be made available to my personal physician, Dr. _____, and to the NUNM Exposure Control Officer in order to comply with state and federal regulations.

_____
Physician Name

_____

_____

_____ _____
Physician Address Physician Phone Number

_____
Print Patient Name

_____ _____
Patient Signature Date

_____ _____
Print Witness Name

_____ _____
Witness Signature Date