**POST-EXPOSURE INCIDENT**

**EXPOSED EMPLOYEE CONSENT FORM**

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**Employee Name** (PLEASE PRINT) **Social Security Number**

**Employee Consent to Blood Testing**

As a result of my exposure to blood or other potentially infectious material, it is recommended that I have my blood tested for HIV (known to cause AIDS), HBV and HCV.

(***Check One***)

* **I hereby give my consent** to such testing.
* **I consent to have my blood tested for HBV, but I decline to have my blood tested for HIV at this time**. I understand that by choosing this option, a sample of my blood will be kept for 90 days, during which period I may change my mind and have my blood tested for HIV at that time.

**My consent** is based on the understanding that:

* 1. My test results will remain confidential and provided only to those who have a need to know in accordance with current federal, state, and local statutes.
  2. I will be provided with counseling whether the tests are negative or positive.
  3. I have been provided with information concerning HIV and HBV, and understand the contents thereof.
  4. I have been given the opportunity to ask questions concerning HIV and HBV testing.
  5. I have received risk behavior guidelines concerning HIV.
  6. I will receive a copy of all test results.

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**Signed** **Date**

**Employer’s Representative:**

*I certify that the above-named individual received a copy of the HIV/HBV information sheets and has had the contents thereof fully explained.*

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**Date** **Employer’s Representative** (PLEASE PRINT)

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**Title**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

This document will be retained in the exposed employee’s medical file.