

**Form 9-a8**

**Blood Testing Consent/Non-Consent Form**

<b>Date of Exposure Incident:</b>		
<b>Hepatitis B Vaccination Status:</b>	<input type="checkbox"/> <b>Series complete</b>	<input type="checkbox"/> <b>In process</b>
	<input type="checkbox"/> <b>Has not been vaccinated</b>	

I, \_\_\_\_\_, consent to being tested, as indicated below, for HIV and/or HBV. I understand that the results of this testing will be kept confidential and will be used to determine appropriate treatment for the individual exposed to my blood or body fluid.

<b>Consent is given to be tested for:</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
HIV (Human Immunodeficiency Virus)	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
HBV (Hepatitis B Virus)	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>

(Employee Name)	(Employee No/SS#)	(Date)

I, \_\_\_\_\_, do not consent to any blood testing. The circumstances for the request to do so have been explained to me and I have no further questions or comments that need to be addressed as I make this decision. I understand that this denial will be kept confidential.

(Employee Name)	(Employee No/SS#)	(Date)