**BLOODBORNE PATHOGEN EMPLOYEE CONSTENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(employee name)**, having possibly sustained an exposure to a bloodborne pathogen(s) during the act of: (check appropriate box)

**\_\_\_\_\_** Rendering aid or assistance to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(the injured person’s name)** an injured individual or;

**\_\_\_\_\_** During the clean up process after an individual has sustained injury

I hereby agree that a blood sample(s) may be obtained from me for the purpose(s) of testing for bloodborne pathogen(s), including the Acquired Immune Deficiency Disease Virus, the Hepatitis B Virus. It is understood that the information so developed is confidential, will not be divulged to others without my permission, will be kept only in my medical file, and is being sought at this time only for my benefit. It is further understood that the results of this testing will be reviewed with me in a timely fashion by a HCP.

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

**(EMPLOYEE SIGNATURE)**

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

**(WITNESS SIGNATURE)**

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

**(DATE)**