

## Document B

### POST EXPOSURE TESTING CONSENT FORM EXPOSED INDIVIDUAL

I was recently involved in an exposure incident at Northwestern Health Sciences University.  
I am the exposed individual.

As this exposure may possibly transmit the hepatitis B virus (HBV) or hepatitis C (HCV) or the human immunodeficiency virus (HIV), I understand that it is important that my blood be tested for Hepatitis B, Hepatitis C, and HIV.

\_\_\_\_\_ I agree to have my blood tested for hepatitis B, hepatitis C, and HIV at the prescribed intervals recommended by the CDC (see below).

\_\_\_\_\_ I decline to have my blood tested at this time.

\_\_\_\_\_ I understand that I may request testing within 90 days.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

\*\*\*\*\*

The Center for Disease Control (CDC) has suggested testing at the following intervals:

- |   | Date  | Results |
|---|-------|---------|
| • At time of exposure ( <u>baseline</u> ) | _____ | _____   |
| • At 6 weeks post-exposure                | _____ | _____   |
| • At 6 months post-exposure               | _____ | _____   |