Date of Exposure Incident:	
Hepatitis B Vaccination Status:	☐ **Series complete** ☐ **In process** ☐ **Has not been vaccinated**

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.

Consent is given to be tested for:		
HIV (Human Immunodeficiency Virus)	☐ **Yes**	☐ **No**
HBV (Hepatitis B Virus)	☐ **Yes**	☐ **No**

(Employee Name)	**(Employee #)**	**(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 #)**	**(Date)**