PINELLAS COUNTY SCHOOLS

BLOODBORNE PATHOGENS POST-EXPOSURE
BLOOD COLLECTION AND TESTING OF SOURCE INDIVIDUAL

Introduction

You have been involved in an incident during which your blood or other body fluids have come in direct contact with an employee of Pinellas County Schools. In order to provide proper medical follow-up for the exposed employee, you are requested to submit to blood collection and testing for the hepatitis B virus (HBV), hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). All costs for HBV, HCV, and HIV testing will be paid by Pinellas County Schools. The tests are voluntary and you may withdraw your consent at any time. The test results will only be disclosed to the exposed employee (if allowed by law) and the licensed healthcare provider evaluating/treating the exposed employee relative to his/her exposure incident. **THE EXPOSED EMPLOYEE AND HIS/HER HEALTHCARE PROVIDER SHALL MAKE NO DISCLOSURE OF SAID MEDICAL INFORMATION WITHOUT A SPECIFIC WRITTEN AND INFORMED CONSENT SIGNED BY YOU, THE SOURCE INDIVIDUAL.**

A "Source Individual", by regulatory definition, means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains, and individuals who donate or sell blood or blood components.
(Ref. 29 CFR l9lO.lO30(b)).

CONSENT

I, _____ , have read and understand the above information regarding the request to have my blood collected and tested for specific pathogenic bloodborne viruses. Due to an exposure to my blood or other potentially infectious materials, I realize that someone may be at risk of acquiring hepatitis B virus (HBV), hepatitis C (HCV), and/or human immunodeficiency virus (HIV)—all serious illnesses. I understand that the tests are voluntary, that I have the right to be tested anonymously, that I may withdraw my consent at any time, and that the test results will be disclosed only to the exposed employee (if allowed by law) and the licensed healthcare provider evaluating/treating the exposed employee relative to his/her exposure incident. Therefore, I hereby consent to the following blood collections/tests (check those that apply):

☐ Hepatitis B Virus (HBV) ☐ Hepatitis C Virus (HCV) ☐ Human Immunodeficiency Virus (HIV)

_____	_____
Source Individual Signature	Witness Signature
_____	_____
Source Individual Address	Affiliation or Address
_____	_____
Date	Date

White - Risk Management Copy - Medical Provider Copy - Source Individual