**BLOODBORNE PATHOGEN SOURCE INDIVIDUAL CONSTENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(injured name)**, having received aid or assistance for an injury as a result of which \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(responder name)** the responder sustained exposure to my blood, blood products or body fluids, hereby agree that a blood sample(s) may be obtained from me for the purposes of testing for bloodborne disease, including the Acquired Immune Deficiency Disease Virus, the virus of Hepatitis B .

It is understood that the information so obtained is confidential, and will be used solely for the purposes of rendering care and treatment to the above referenced healthcare person, and will be reviewed with me in a timely fashion by a professional HCP Health Care Provider.

**Exposure** is construed to mean the contamination of abraded skin or mucous membranes by the blood, blood products, or body fluids of the treated individual. A finger stick, abrasion or a laceration sustained in the process of rendering care that allows the blood, blood products, or body fluids of the injured person to enter the body of the responder.

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**(INJURED INDIVIDUAL SIGNATURE)**

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**(WITNESS SIGNATURE)**

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

**(DATE)**

**Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Office Telephone:** **( )**\_\_\_\_-\_\_\_\_\_ **x**.\_\_\_\_\_\_