Roger Williams University
Health Service
One Old Ferry Road Bristol, RI 02809 401-254-3156

Consent to Test for HIV / HEPC / HEPBsAG
Source Patient

Employee-related Exposure Event

Patient name:_____________________________ Date of Birth:___________________

1. An employee of Roger Williams' University has been exposed to my bodily fluids, and these tests are a part of the Exposure Control Plan, not a part of my medical treatment. I understand that Roger Williams University has this Exposure Control Plan to comply with OSHA29 CFR Ch. XVII 1910.1030.

2 I understand that the test results will be given to my Primary Care Physician, Occupational Medicine Physician, and the exposed employee, exposed on _____________. Results will also become a part of the exposed employee's confidential employee health record. Employees of Roger Williams University are required to sign confidentiality statements in relation to this type of information, in accordance with M.G.L. c. 111,870F,HLTV-III Test Confidentiality and informed Consent.

3. I understand that this test and the results will not be a part of my medical record or the university's information system, nor will my insurance company be billed or made aware of tests or results.

4. As with any test, 380.23,[]13(und)9e4(sta4(nd t29E[3.]23-2/ 1 p5e4()91 _.nt cou3 T(5a)5(e-130g is av5e)20(a23-b