1001 Beall Lane * PO Box 3697 * Central Point, OR 97502 * 541-734-5150 * fax: 541-245-9188

# SOURCE INDIVIDUAL CONSENT/WAIVER TO PERFORM LABORATORY TESTING

*** Complete, sign, date and return to the Human Resources Department***

I have been informed that during the performance of his/her duties, an employee of SOCFC, Inc. may have been exposed to a bodily fluid of mine. In order to assess and minimize the risk to the exposed employee, I give my consent for a blood sample to be drawn by a licensed laboratory or health care provider to detect the presence of an infectious organism including Hepatitis B and HIV. (NOTE: The Center for Disease Control recommends that testing for Hepatitis C be included in the basic profile.)

## CONSENT TO PERFORM LAB TESTING

Results of my lab test may be made available **ONLY** to my personal health care provider.

HCP Name:_______________________________________________

HCP Address:_____________________________________________

HCP Phone:______________________________________________

Source Individual Signature (or parent/guardian) _______________________________________________

Print Name ____________________________________________________ Date ____________________

-----------------------------------------------------------------OR-------------------------------------------------------

## WAIVER TO PERFORM LAB TESTING

I have been offered and have decided to waive my right to be tested for the infectious diseases listed above.

Source Individual Signature (or parent/guardian) _______________________________________________

Print Name ____________________________________________________ Date ____________________