MEMORIAL UNIVERSITY
Faculty of Medicine

DECLARATION: BLOOD BORNE PATHOGENS SEROLOGY EXPECTATIONS

☐ I have read and understand: the College of Physicians and Surgeons of Newfoundland and Labrador's (CPSNL) Blood Borne Pathogens Policy; and the Faculty of Medicine's Blood Borne Pathogens Policy.

☐ I understand that I have an ethical obligation to be aware of my serological status.

☐ I confirm that if my serological status related to the CPSNL's Blood Borne Pathogens Policy is positive, I will notify the CPSNL in accordance with its policy.

☐ I agree that I will repeat the blood borne pathogens testing in accordance with the CPSNL's Blood Borne Pathogens Policy.

_____ _____

Name *(please print)* Program

_____ Date: _____

Signature dd mm yyyy

The personal information requested on this form is collected under the general authority of the Memorial University Act (RSNL1990 CHAPTER M-7) for the purpose of ensuring that you are aware of the expectations regarding blood borne pathogens and to form part of your student record.