



Kalamazoo County

Health & Community Services

Linda Vail Buzas, MPA
Director, Health Officer

CLIENT ACKNOWLEDGEMENT FORM

Counseling Date: _____

I, _____, have received education and counseling regarding my Human Immunodeficiency Virus (HIV) positive test status.

I have been informed that the following behaviors by me could transmit the virus to others:

1. Unprotected oral, anal or vaginal sex.
2. Sharing needles of any kind, for any purpose.
3. Donating blood, organs, plasma or any other tissue.
4. Performing exposure-prone invasive health care procedures without following universal precautions.

I have been informed that before I engage in any activity where there is a risk of exchanging body fluids (semen, vaginal secretions or blood) I must inform my partner that I am infected. I understand what actions the Kalamazoo County Health & Community Services Department may have to take should I not follow these instructions, including any actions under the Michigan Public Health Code, Section 333.5201 et seq.

My signature below means that I understand the safe behaviors that have been discussed with me by the Health & Community Services Department staff.

Signed: _____ Date of Birth _____

Date: _____

Witness Signature: _____

Date: _____

i: clntack
revised 10/07

