STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

Employee Informed Waiver of Medical Treatment
(Release of Responsibility)

I, _____, date of birth, _____ have had an exposure to blood or other potentially infective fluids on date:_____. The possibility of infection by bloodborne pathogens and serious sequel, and the potential for becoming ill and having long term problems as a result of this exposure have been explained to me. Furthermore, I understand that by knowingly and voluntarily waving such treatment, which I herby do, my refusal of such treatment or procedure may cause chronic disease, permanent disability and seriously imperil my life.

I herby release from liability the State of Alaska, Department of Corrections, as well as employees, together with all physicians and medical personnel in any way connected with me as a patient for the above described condition, for my refusal to follow their medical recommendations.

_____	_____
Name	Date
_____	_____
IHCO	Date
_____	_____
Witness	Date
_____	_____
Witness	Date