

**MINISTRY OF HEALH**

**APN Consent form**

Dear Sir/Madam my name is \_\_\_\_\_\_\_\_\_\_\_\_ a health worker at \_\_\_\_\_\_\_\_\_\_\_\_\_ Health facility. I would like to invite you to participate in a program for identified HIV-positive persons. We will ask you for information about you and your sexual partners. Knowing yours and your partners’ HIV status is important for you and your partners’ health. If you agree we will contact your sexual partners for HIV testing. All the information shared with us will be kept confidential and we will not reveal your identity to any of your named sexual partners. Please ask any questions you have about the program and I will do my best to answer them.

Please sign below to indicate your consent to participate in this program.

Clients

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature or thumb print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client ART # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health worker

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature or thumb print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_