STI/HIV Counseling & Testing Rapid CLIA Incident Report

* Denotes required fields.

* Date and Time Reported: ____________________

* Facility Name: ____________________

* Facility ID #: ____________________

* Name of person reporting: ____________________

* Phone Number: ____________________

* Email ____________________

Please indicate below, the reason for submitting the Kansas HIV Counseling and Testing Rapid CLIA Incident Report:

❍ Defective Test Kit
❍ Faulty/Malfunctioning Test Kit
❍ Operator Malfunction
❍ Invalid Rapid HIV Test Kit
❍ Invalid or Defective Controls

If the Rapid HIV kit was invalid, faulty or defective, was te client retested?

❍ Yes
❍ No

If YES, please indicate the HIV Test Form ID and Client ID used to re-test.
Client ID #: ____________________
Test Form ID #: ____________________

* Please describe the circumstances regarding the incident:

____
____
____

If Follow-up activities are required, please describe below:

____
____

PLEASE RETAIN A COPY OF THIS SUBMISSION FOR YOUR RECORDS

Questions: Contact Camille Cushinberry at (785) 296-7716, fax (785) 559-4229 or email ccushinberry@kdheks.gov.