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 the 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:

________________________________________________________________
________________________________________________________________