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| Mandatory Testing Order (MTO) Application | |
| Mandatory Disease Testing Act 2021 No 13 | |
| Use this form to submit a request to be reviewed for a Mandatory Testing Order.  The MTO application made by the Worker in relation to a Third Party will be assessed against the following criteria as per the Mandatory Disease Testing Act 2021 Section 8:  The Worker has come into a contact with the bodily fluid of the Third Party, and   1. The contact occurred:  (i) in the execution of the Worker's duty, and  (ii) as a result of a deliberate action of the Third Party, and  (iii) without the consent of the Worker.   Please Note:   * An application may not be made if the third party is under the age of 14 years. * An application may be made only if the worker has consulted a relevant medical practitioner in accordance with section 9. * An application must be made to the worker’s senior officer within 5 business days after the contact   Once Submitted, your application will be assigned to a relevant Senior Officer for review.  If your application is progressed, the allocated Senior Officer will proceed with the Mandatory Testing Order if the Third Party is not deemed vulnerable and consent for a blood test is not provided by the Third Party. If the Third Party is deemed vulnerable, an application will be made to Court to proceed with the Mandatory Testing Order.  [Additional information and CHO Guidelines are available online.](https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx) | |
| Applicant Details | |
| Name\*: | Phone Number\*: |
| Employee number: | Email address\*: |
| Incident Details | |
| Date of incident\*: | Supervisor’s Name: |
| Time of incident\*: | Incident Number: |
| Please provide a detailed description of the incident\*: | |
| Please acknowledge and confirm the following statements:   * The contact occurred during execution of duties. * The contact with the Third Party's bodily fluid was as a result of a deliberate action of the Third Party. * The worker did not consent to the contact with the bodily fluid. * The Third Party is not under the age of 14. * A relevant medical practitioner has been consulted. * The date of contact is within 5 days of the application. * The Worker’s name will likely be disclosed to the Third Party.   I acknowledge and confirm the above statements are true and correct.\* | |

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| Third Party Details | | |
| Third party name\*: | Third party reference No (if applicable)\*: | |
| Third party address: | Third party email address: | |
| Third party phone number: | | |
| Is third party 14 or over?  Yes  No | | |
| Contact Details – Detailed Description | | |
| Date and time of contact\* (*Date of contact should be within the last 5 business days of application*) | Location of contact\* (*Please include at minimum the Suburb where the incident occurred)* | |
| Please provide a detailed description of the bodily fluid contact and surrounding circumstances.\* | | |
| Select contact fluid type(s):\*  Saliva  Blood  Semen  Faeces | | Select the type(s) of contact:\*  Needle stick injury and other penetrating injuries involving contamination of bodily fluids  Bodily fluid contact possibly containing blood with broken skin, mouth or eyes  Bites that break the skin  Bodily fluids contact that did not contain blood with broken skin, mouth, eyes  Bodily fluids to intact skin, clothing and skin-to-skin contact. |
| Any other details you wish to add regarding the contact? | | |
| Medical Practitioner Details | | |
| Enter details of the relevant medical practitioners seen *as a result of incident*.\* | | |
| Medical practitioner name\*: | Medical practitioner phone number\*: | |
| Medical practitioner email address\*: | | |
| Medical practitioner address\*: | | |
| Name of medical practice where medical practitioner works\*: | Medical practice phone number\*: | |
| Medical practice email address\*: | | |
| Medical practice address\*: | | |
| Did the medical practitioner provide you with written advice?\*  Yes  No  If yes, please attach a copy of the written medical advice to this application. | | |
| Enter details of your medical practitioners you wish to *have results shared with*.\* | | |
| Medical practitioner #1 | | |
| Medical practitioner name\*: | Medical practitioner phone number\*: | |
| Medical practitioner email address\*: | | |
| Medical practitioner address\*: | | |
| Name of medical practice where medical practitioner works\*: | Medical practice phone number\*: | |
| Medical practice email address\*: | | |
| Medical practice address\*: | | |
| Medical practitioner #2 (optional) | | |
| Medical practitioner name\*: | Medical practitioner phone number\*: | |
| Medical practitioner email address\*: | | |
| Medical practitioner address\*: | | |
| Name of medical practice where medical practitioner works\*: | Medical practice phone number\*: | |
| Medical practice email address\*: | | |
| Medical practice address\*: | | |
| Medical practitioner #3 (optional) | | |
| Medical practitioner name\*: | Medical practitioner phone number\*: | |
| Medical practitioner email address\*: | | |
| Medical practitioner address\*: | | |
| Name of medical practice where medical practitioner works\*: | Medical practice phone number\*: | |
| Medical practice email address\*: | | |
| Medical practice address\*: | | |
| I provide authorisation for the medical practitioner(s) listed above to receive the third party's blood test results on my behalf.\* | | |

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| Please review the following statements and provide consent to:   * The Senior Officer discussing the consultation with the relevant medical practitioner concerned * Obtaining the Worker's medical records related to the contact, if the application does not include a copy of the written advice received from the relevant medical practitioner.   I consent to the above statements.\* | |
| Third Party Vulnerability | |
| Does the third party appear to be a vulnerable third party?\*  *Vulnerability types:*  *(a) is at least 14 years of age but under 18 years of age, or*  *(b) is suffering from a mental illness or mental condition, or is cognitively impaired, within the meaning of the Mental Health (Forensic Provisions) Act 1990, which significantly affects the vulnerable third party's capacity to consent to voluntarily provide blood to be tested for blood-borne diseases*  Yes  No | |
| If yes, please indicate whether:  The Third Party is:\*  At least 14 years of age but under 18 years of age.  Yes  No | |
| The Third Party appears to be:\*  Suffering from a mental illness or mental condition, or is cognitively impaired, within the meaning of the Mental Health (Forensic Provisions) Act 1990, which significantly affects the vulnerable third party's capacity to consent to voluntarily provide blood to be tested for blood-borne diseases.  Yes  No  Unknown | |
| Acknowledgement | |
| Please review the following:  Information given by me in this application to any person exercising functions under this Act is true and correct. I understand that it is an offence punishable by imprisonment to give information that is false or misleading in a material particular.  By checking this box, I agree to the above statement.\* | |
| Applicant Name: | Date: |
| Applicant signature: | |