Replacement Blood Drive Consent Form

Please email completed form to kberrier@medicblood.org or fax to 865-521-2642
Please skip questions that don't pertain to you (i.e. spouse, church, etc.)

Patient's Full Name:_____

DOB: _____ Last Four of SSN:_____

Phone:_____ Email:_____

Mailing Address: _____

Hospital Where Blood Was Received:_____

Patient's Employer: _____

Spouse's Full Name: _____

Spouse's Employer: _____

Church: _____

(The following four lines are to be completed when the person receiving blood is a minor.)

Parent 1's Name:_____Number_____Email_____

Parent 1's Employer:_____

Parent 2's Name:_____Number_____Email_____

Parent 2's Employer: _____

I understand that MEDIC may use the patient's name, picture, and other information for marketing purposes. I've also read and understand MEDIC's membership policy.

_____ _____
(Printed Name) Date

_____ _____
Signature Relationship to Patient

(For Office Use Only)
Replacement Drive Approved_____

Account Assigned to:_____

MEDIC
REGIONAL BLOOD CENTER