MEDIC
REGIONAL BLOOD CENTER

Replacement Blood Drive Consent Form

Please email completed form to kberrier@medicblood.org or fax to 865-521-2642.

Patient's Full Name: _____

Patient's DOB: _____ Last 4 Digits SSN: _____

Hospital where blood was received: _____

Patient's Mailing Address: _____

Patient/Guardian Phone: _____ Church: _____

Patient/Guardian Email: _____

Guardian's Name (if patient is a minor): _____

Patient/Guardian's Employer: _____ Guardian's DOB: _____

Spouse Name: _____ Spouse DOB: _____

Spouse Email: _____ Spouse Phone: _____

Spouse Employer: _____ Other Contact: _____

I have read and understand MEDIC's membership information and policies. I understand that by signing this form, MEDIC may use the patient's name, picture or general information for marketing purposes.

_____ _____

Printed Name Date

_____ _____

Signature Relationship to Patient

For MEDIC Personnel Only:

Replacement Drive Approved By: _____ Date Approved: _____

Account Reviewed on: _____ Account Assigned to: _____