Replacement Blood Drive Consent Form
Please email completed form to jowens@medicblood.org or tsavage@medicblood.org.

Patient's Full Name: ____________________

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

Hospital where blood was received: ____________________

Patient's Mailing Address: ____________________

Patient/Guardian Phone: ____________ Patient/Guardian Email: ____________

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

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

Spouse Name: ____________ Spouse DOB: ____________

Spouse Phone: ____________Spouse Email: ____________

Spouse's Employer: ____________________

Secondary/Replacement Drive Contact Name: ____________________

Secondary/Replacement Drive Contact Email: ____________________

Secondary/Replacement Drive Phone Number: ____________________

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 Assigned to: ____________________