Replacement Blood Drive Consent Form

Please email completed form to aprice@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: