Multiphasic Blood Analysis
Saturdays, March 28, May 16, June 20
7-10 a.m.

Saturday, March 28

☐ **Morgantown North Rotary**
Clear Mt. Bank (Sabraton)

☐ **Cheat Lake Rotary**
Clear Mt. Bank (Pierpont)

☐ **Westover Rotary**
Fyzical (Formerly Dynamic PT
In Westover)

Saturday, May 16

☐ **Morgantown North Rotary**
Clear Mt. Bank (Sabraton

☐ **Cheat Lake Rotary**
Clear Mt. Bank (Bruceton Mills)

☐ **Westover Rotary**
Primary Care Core

Saturday, June 20

☐ **Morgantown North Rotary**
Clear Mt. Bank (Sabraton**)**

☐ **Cheat Lake Rotary**
Health Works (Cheat)

☐ **Westover Rotary**
Fyzical (Formerly Dynamic PT in
Westover)

No walk-ins will be taken at the above locations.

The cost for the preregistered multiphasic blood analysis is $35. A Prostate Specific Antigen (PSA) blood test (for Men only), a Thyroid Stimulating Hormone (TSH) screening and the Glucose A1-C are available for an additional cost $15 each. Vitamin D test is available for $20. **No registrations will be taken over the phone**.
Printable forms are available on out web page at www.monhealth.com. A confirmation letter will be sent out after payment and registration are received. Please call (304) 285-2730 if you have any questions.

Make checks payable to Mon Health and mail to: **Mon Health**
P.O. Box 1615
Morgantown, WV 26570

Please Make your 1st & 2nd Choice: [ ] 7AM – 8AM [ ] 8AM-9AM [ ] 9AM- 10AM

Name____ _______**Birth Date (required)**_____/____/_____ Sex M / F

Address____**City**_________________________ **State**__________**Zip**____________

Email____**Phone (** **)**____________________**SS#**_____________
Last four digits

Please Check: [ ] Multiphasic $35 [ ] PSA (Men Only) $15 [ ] Thyroid $15 [ ] Glucose A1-C $15 [ ] Vitamin D $20

Amount Enclosed $________________

Informed Consent (Please read and sign): I allow the agents of Mon Health Hospital System to draw a sample of my blood for testing in the Multiphasic Health Screening and/or Prostate-Specific Antigen (PSA) and/or Thyroid Stimulating Hormone (TSH) and/or Glucose A1-C screening. I understand that these tests are for screening only. If there are abnormalities, it will be my sole responsibility to seek further evaluation and treatment as recommended. I understand it is not uncommon to experience some bruising (hematoma) at the site where the needle entered my arm for the blood specimen collection. By way of my signature below, I release Mon Health Medical Center, Mon Health Hospital System, Inc., their respective directors, officers, agents and employees from liability arising from this blood draw.

Notice of Privacy: I understand that the Mon Health Hospital System Privacy Notice that describes how my health information may be used for the purpose of treatment and/or payment of health care operations will be available to me at the site of my blood draw.

☐ From time to time Mon Health will send you information about our services that we feel would be of interest to you. If you are not interested please check the box.

Signature____ Date ___________________________

REGISTRATION FORM AND PAYMENT MUST BE RECEIVED BY March 13, May 1 OR June 5 Depending On The Date You Choose