

Health Fair Saturday, April 18, 2020

Canaan Valley Resort & Conference Center, Bear Paw Ski Lodge

Registration Form: **Must be postmarked by March 13th**. Please write one check for total amount.
Prices good on April 18, 2020 only. Please call 304-285-2730 if you have questions. Make check are payable to **Mon Health Medical Center**. Forms returned to:

Mon Health Community Wellness
P.O. Box 1615
Morgantown, WV 26507

Limited Spaces Available

(Check all that apply)

Multiphasic _____ \$15

Don't forget...for the most accurate results, multiphasic participants must fast for 12 Hours. Medication may be taken with small sips of water.

PSA _____ \$15

PSA (Prostate Specific Antigen) screening usually for men over the age of 50

Thyroid _____ \$15

TSH (Thyroid Stimulating Hormone)

Amount _____

Free Screenings

Please see back of form

Choose a Time: [] 7:00-8:00 [] 8:00-9:00 [] 9:00-10:00 [] 10:00-11:30

You will receive a confirmation letter in the mail and your test results will be mailed to you.

Name _____ Birth Date(required) ____/____/____ Sex ____

Address _____ City _____ State _____ Zip _____

Email _____ Last four of SS# _____

Informed Consent (Please read and sign): I allow the agents of Mon Health Medical Center 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) screening. I understand that these tests are for screening only and, 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, their respective directors, officers, agents and employees from liability arising from this blood draw. To avoid bruising, please follow the instructions below:

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.

Notice of Privacy: I understand that the Mon Health 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.

Signature _____ Date _____