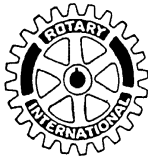


# 25th Annual Community Wellness Screening

....sponsored by



Martinsburg  
Rotary

&



WVUH•EAST  
WEST VIRGINIA UNIVERSITY HOSPITALS

**Saturday, April 17, 2010**

**6:00 — 10:00 a.m.**

**in the McCormack Center**

*(located on City Hospital's Campus)*

**The cost of the general health blood screening is \$40. A Prostate Specific Antigen (PSA) blood test (for men only) is available for an additional \$35.**

Registration form (below) and payment must be received by April 2, 2010.

Please make check payable to The Wellness Center.

**No reservations will be taken over the telephone.**

You will receive a letter confirming your scheduled appointment.

Every effort will be made to accommodate your preferred appointment time; however, preference will be granted on a first-come-first-serve basis. For questions, call 304-264-1673.

**Please print legibly and mail with payment to The Wellness Center at City Hospital, 2000 Foundation Way, Suite 1200, Martinsburg, WV 25401. Attention: Jennifer Hess**



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Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Male  Female

Check if additional PSA screening is desired (for men only)

Please indicate 1st Choice and 2nd Choice Appointment Time:

\_\_\_ 6:00--7:00 a.m. \_\_\_ 7:00--8:00 a.m. \_\_\_ 8:00--9:00 a.m. \_\_\_ 9:00--10:00 a.m.

*Informed Consent: Please read and sign.*

I hereby give my consent for a sample of my blood to be taken and used for a general health blood screening and/or Prostate Specific Antigen (PSA) Screening. I understand that it is not uncommon to experience some bruising (hematoma) at the site where the needle entered my arm for the blood draw. I understand that these tests are for screening purposes only and, if there are any abnormalities, I will be informed. I also understand that it is my sole responsibility to seek further evaluation and treatment as recommended. I voluntarily consent to the screening exam and release West Virginia University Hospitals-East and its affiliates, and each of their respective directors, officers, agents, and employees from all liability, damages, costs and expenses arising from the exam.

*Notice of Privacy:* I understand that the WVUH-East Health System Privacy Notice that describes how my health information will be used for the purpose of treatment and/or payment of healthcare operations will be available to me at the blood draw.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_