MY CONCIERGE MD
Executive Health

*Employee Wellness Program COVID-19 Pandemic Consent*

Dear Employees of _____

Your employer _____, cares about you and your wellbeing!

**Mission**

Ensure that you and your colleagues are healthy and to keep a healthy work environment to protect you and your loved ones.

**What this entails**

We will be conducting  a PCR swab test to rule out active infection of COVID-19.

**Procedure**

The COVID-19 PCR Swab will take a swab of either the inside of your nose or mouth and is performed quickly.

**Permission**

A final report with your COVID 19 test results will be emailed to you within 1 to 2 days. If any results are abnormal, we will be able to make recommendations that you can follow.

**9301 Wilshire Blvd Suite #405A**
**Beverly Hills, CA 90210**
**310-299-8959 Office**
**310-492-9839 Fax**
**info@myconciergemd.com**
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***In the event that test results indicate an infection, we will ask you to quarantine for the safety of the workplace and your family and give us permission to notify your employer.***

**Risks**

There may be some irritation to the inside of your nose. Your test may also be collected by a swab of the inside of the mouth.

**Benefits**

*Find out if you have an active COVID-19 Infection*

**General Information**

Your participation in this testing is voluntary. If you agree to take part, you can later withdraw.

**Costs**

It will not cost you anything for the blood spot collection or tests. Your employer has kindly taken care of all costs.

**Liability**

In the unlikely event of any injury resulting from the finger stick(s), your employer will not be held liable.

**Privacy**

You authorize the release of your results to your employer for the safety of the workplace.

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**Consent**

I have read all of the above, asked questions and received satisfactory answers about what I did not understand. I agree to have my blood and or PCR swab collected for this study. I have been given a copy of this consent form._____Name of Participant (Please Print)_____Signature of Participant Date_____Name of Person Obtaining Consent (Please Print)_____Signature of Person Obtaining Consent Date_____Translator (only if applicable) DateLocation of Data Collection:

_____

First Name

Last Name

Date of birth

Telephone

Email Address

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