INTERNATIONAL BOARD OF BLOOD MANAGEMENT
AUTHORIZATION FOR RELEASE OF INFORMATION
AND CASE VERIFICATION FORM

This page must be signed by the applicant and an immediate supervisor or other hospital authority.

Authorization for Release of Information

This section MUST be signed by the applicant.

I certify that all information submitted in this report is accurate and correct. Any misrepresentation of the information will result in a revocation of the application or a termination in certification by the International Board of Blood Management. I hereby authorize the Immediate Supervisor or other Hospital Authority to verify the accuracy of the information on the submitted Clinical Activity Report.

Signature: _____

Printed Name: _____

Date: _____

Case Verification

This section MUST be signed by an immediate supervisor or other hospital authority.

FOR USE BY IMMEDIATE SUPERVISOR OR OTHER HOSPITAL AUTHORITY ONLY

Cases verified: _____ Cases not verified: _____

Reasons for lack of verification:

_____

_____

Signature: _____

Printed Name:_____

Title: _____

Hospital or Company: _____

Address: _____

Date: _____