GUAM VISITORS BUREAU
SETBISION BISITAN GUÅHAN

Clinic: **AMERICAN MEDICAL CENTER**

## PATIENT CONSENT FORM

| | |
|---|---|
| Name: | |
| Date of Birth: | |
| Gender: | ☐ Male ☐ Female ☐ Other |
| Country: | ☐ Japan ☐ Korea ☐ Taiwan ☐ Philippines<br>☐ CNMI ☐ Palau ☐ FSM ☐ USA, please specify: _____ (State)<br>☐ Other, please specify:_____ |
| Date of Arrival: | |
| Date of Departure: | |
| Type of Test: | ☐ PCR<br>☐ Other, please specify _____ |

By signing below, I _____ **(patient)** agree to participate in the Guam Visitors Bureau's free COVID-19 testing program for returning visitors. The information that I have provided is true and correct. I understand that the Guam Visitors Bureau is not liable for any reactions, injuries, bodily harm, or distress that may result from testing or late or indeterminate test results. I authorize **AMERICAN MEDICAL CENTER** **(clinic)** to release my patient information to include my results, copy of either my passport, driver's license, or birth certificate, copy of my arrival boarding pass, and copy of my departure confirmation.

_____ _____

**Signature of Patient / Parent or Legal Guardian** **Date**

For official use only

Result: ☐ Positive
☐ Negative
☐ Indeterminate

☐ Copy of passport, driver's license, or birth certificate
☐ Copy of visitor's arrival boarding pass
☐ Copy of visitor's departure confirmation