



WOT PARTICIPANT MEDICAL CONSENT FORM

I, _____, agree voluntarily and with no reservation to receive a confidential medical exam, which includes a gynecological exam and a blood test. I have received an explanation of how the tests will be conducted and the impact that the test results could have for my personal health.

Signed by WOT Participant: _____ Date: _____

Witnessed by WOT Program Supervisor: _____ Date: _____

Approved by WOT Program Advisor: _____ Date: _____