International Board of Blood Management

AUTHORIZATION FOR RELEASE OF INFORMATION
AND CASE VERIFICATION FORM

Email: ibbm@amsect.org
Website: www.intbbm.org

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: ________________________________________________________________________________________