



## PARTICIPANT EXCLUSION FORM

You may add additional Participants to exclude on the form below.

<b>Participant's Name</b>	<b>Participant's address or phone number</b>
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<b>Participant's Name</b>	<b>Participant's address or phone number</b>
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PATIENT/LEGAL REPRESENTATIVE	Entity Consent Received By WITNESS *
_____ <b>Print Patient Name:</b>	* If you are <b>NOT</b> completing this form in a Participant's office, you must have a witness complete the information below.
_____ <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Patient Date of Birth:</b>	
_____ <b>Signature of Patient or Patient's Legal Representative</b>	
_____ <b>Date of signature</b>	
_____ <b>Patient Address</b>	
_____ <b>Print Name of Patient's Legal Representative (if applicable)</b>	_____ <b>Print Name of Witness</b>
<b>Relationship of Legal Representative to Patient (if applicable)</b> <input type="checkbox"/> parent <input type="checkbox"/> healthcare agent/proxy <input type="checkbox"/> guardian <input type="checkbox"/> other _____	_____ <b>Signature of Witness</b>
	_____ <b>Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)</b>