Building Trades National Medical Screening Program

Consent Statement
To Participate in the Beryllium Lymphocyte Proliferation Test (Be-LPT)

Principal Investigator: Knut Ringen, Dr. P.H.
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8484 Georgia Avenue, Suite 1000
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Sponsor: U.S. Department of Energy, Office of Health, Safety, and Security

PARTICIPANT'S AUTHORIZATION

I have read: (Check and initial items to indicate that you have read them).

☐_____ the attached information about the Beryllium Lymphocyte Proliferation Test (Be-LPT) and I have had an opportunity to ask questions.

☐_____ the test results are kept confidential by the Building Trades National Medical Screening Program staff and that none of my personal information is made known to the testing laboratory that performs the Be-LPT analysis.

☐_____ that the results of this Be-LPT test are reported to the examining physician and the Building Trades National Medical Screening Program and they will advise me about them.

☐_____ that if the results of any test suggest a health problem, whether related to chronic beryllium disease or not, this will be discussed with me by the examining physician.

☐_____ that I am free to withdraw without penalty or loss of benefits at any time from all or any part of the program for which I am volunteering.

☐_____ that the results of any tests, examinations, statistical analysis, or research using data from this screening program may be published or presented at scientific meetings, but that I will not be identified personally.

☐_____ that my personal identifiers such as name, address, phone number, or Social Security number will not be included in any reports generated by the Building Trades National Medical Screening Program.

☐_____ that the records of my participation in this Program and the results of any tests or examinations that I consent to have as a part of my follow-up are private and confidential, and that they will be protected from disclosure, except with my consent, or as required by law or a court order.

☐_____ that if I apply for a different job or for insurance, I may be requested to release my medical records from this Program, which will include the results of my Be-LPT, to a future employer or to an insurance company.

☐_____ that if I have additional questions about this study, or my participation in it, I can contact Dr. Knut Ringen, CPWR, 1-800-866-9663 or the Central Department of Energy Institutional Review Board at 865-576-1725.

☐_____ that I will be given a copy of the Beryllium Lymphocyte Proliferation Test Fact Sheet and this Consent Form after I and the other necessary program representatives have signed it.

☐_____ that I may have the Be-LPT test through my own physician outside this program, but if I do, I will have to pay for the test myself or through my personal medical insurance.

Check and initial this item to indicate your consent:

☐_____ I consent to have the Beryllium Lymphocyte Proliferation Test (Be-LPT) conducted on a sample of my blood.

Name of participant (please print)_____SSN_____

Signature of participant_____
(Date) (Time AM/PM)

_____
Signature of witness to the participant's signature (Date) (Time AM/PM)

_____
Printed name of witness

I have explained and discussed any questions that the above participant expressed concerning the Be-LPT test, and the implications of this test.

_____
Authorized representative's signature (Date) (Time AM/PM)

_____
Authorized representative's printed name