



Medical Clearance Note for Blood Donation

| Patient Information | |
|--|-------------------|
| Date: | Full Name: |
| DOB: | Phone Number: |
| Provider Authorization | |
| I have reviewed this patient's medical history and determined that they are medically stable to donate blood. This patient is voluntarily donating and has no conditions for which phlebotomy will promote their own health. | |
| Name of Office: | Office Telephone: |
| Signature of Provider (MD, DO, PA-C, NP): | Date: |
| <i>Please fax this form to 907-563-1371 or bring to a Blood Bank of Alaska location.</i> | |