NORTHEAST
WI Technical College

Dear OB Ultrasound Volunteer:

Thank you for volunteering your time to help with our Educational Ultrasounds. We hope that you enjoy the Northeast Wisconsin Technical College experience. The students and faculty appreciate your valuable time and are excited for your arrival.

Enclosed, please find the policy sheet that needs to be filled out completely and returned before making an appointment. After the scheduler receives your completed policy sheet, we will call or email you to schedule an appointment.

Please send the signed form to:

Fax: 920.491.2660

OR e-mail: collegeofalliedhealth@nwtc.edu

If you have any questions or concerns, regarding the policy sheet or the educational ultrasound, please do not hesitate to call 920-498-6283. Again, thank you for your help.

Sincerely,

Diagnostic Medical Sonography Students and Faculty

NORTHEAST
WI Technical College

Diagnostic Medical Sonography Obstetrical Model Consent Form

I, _____, agree to be a volunteer student model at Northeast Wisconsin Technical College (the "College") for the Diagnostic Medical Sonography program. I acknowledge an ultrasound scan is conducted for the purpose of training students and will not be evaluated by college staff or students for medical purposes. As such, the Supervising Ultrasound Faculty and students will not fully evaluate the desired exam checked below and make no representations that the volunteer is receiving any medical diagnosis or treatment. I acknowledge that the College will use the scan for educational purposes but will not disclose any personally identifiable information about me or my medical information to any party. I further acknowledge that the images taken as a result of the ultrasound scan will remain the property of the College.

I understand that there is the possibility the ARDMS certified Supervising Ultrasound Faculty and/or students may incidentally discover potential areas of diagnostic concern during this learning opportunity; therefore, I give permission to NWTC and its staff to forward such information to the below listed healthcare provider. I also understand that NWTC will *not* be responsible with any further follow-up with me or my physician. I agree to be personally responsible for following up with my physician for all medical care.

By signing this form, I acknowledge that I have had a previous physician approved sonographic examination prior to volunteering for this program at the college. I have notified my physician of my intent to participate in a sonographic student training session. My physician has reviewed this document with me and has approved my intent to participate as a volunteer. My physician's phone number has been provided to the College in case post-session contact is necessary.

Name of Primary Health Care Provider or OB/GYN:_____

Phone Number of Health Care Provider or OB/GYN: _____

Provider Address: _____
Street City State ZIP

Fax # of Provider: _____

Physician Consent

I, _____, am the physician for the below named patient, and I hereby agree that they are medically fit to obtain a sonographic exam from the college.

Physician's Signature: _____ Date: _____

Model Consent

Model Name: _____ __ Date of Birth:_____

Address:_____
Street City State ZIP

Phone number: _____ Email address: _____

Signature: _____ Date: _____