NORTHEAST
WI Technical College

Diagnostic Medical Sonography
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.

I understand that this consent will be for the □Spring □Fall or □Summer (pick one) session. I may revoke this consent at any time. I will be volunteering to be a model for ultrasound scanning of (please which apply).

□ Abdomen □ Gynecology □ Vascular □ Cardiac

□ Small Parts (Thyroid, Breast, Scrotum, and/or Musculoskeletal)

□ I understand that the sonographer or model may request for an exam to be chaperoned or video recorded.

□ I choose to decline video recording for the following exams: _____

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

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

Name and Address of Medical Office: _____

Model Name: _____ Date of Birth: _____

Model Address: _____
Street City State ZIP

Model Signature: _____
Name Date