COVID-19 SAFETY PROGRAM ACKNOWLEDGEMENT FORM

You are consenting to participation in a COVID-19 Safety Program. As part of this program, you may be asked to participate in a Medical Exam, or undergo laboratory testing for COVID-19 diagnosis, prevention, and treatment. The Medical Exam and/or COVID-19 Swab test may be purchased by an employer, state agency, or other purchasing organization ("Purchasing Organization") as part of the COVID-19 Safety Program.

Purpose of the Medical Exam. This medical exam is to help determine if you have Covid-19. A negative test result does not ensure that you do not have Covid-19. (No test is perfect.) Despite a negative test result, as the CDC advises if you exhibit the following symptoms, you should still self- quarantine at home for 14 days: cough, shortness of breath or difficulty breathing, and at least two of the following: fever (above 100.4 degrees Fahrenheit), chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell. If you develop any of the following emergency warning signs for COVID-19, get emergency medical attention immediately: trouble breathing, persistent pain or pressure in the chest, new confusion or inability to arouse, bluish lips or face.

You agree to seek medical help locally if you exhibit any of the foregoing symptoms, and that where appropriate and possible, a patient-provider relationship is being established between you and a medical group or designee of the Purchasing Organization.

Explanation of the Medical Exam and Associated Risks. This medical exam will include the following:

1. **Interview and exam.** You may undergo an interview in person, on the phone, or complete a questionnaire and a physical exam.
2. **Swab test.** You will use a special swab to take a sample from your nose. This may feel uncomfortable. These effects are temporary.
3. **Venipuncture ("blood draw"**). We will introduce a small needle into your vein to gently draw some blood for Covid-19 antibody tests.

Informed Consent

I understand and consent to 1) Participation in the COVID-19 Safety Program, 2) Interview and/or physical exam, 3) Swab test for COVID-19, 4) Blood draw, and 5) The sharing of my interview, physical exam, swab test results, and blood draw results with my employer or test purchasing organization, and physicians or healthcare providers involved in my healthcare, consistent with HIPAA and all other relevant privacy laws and regulations..

I am told that COVID 19 is not well understood, and that tests for COVID-19 are being developed and improved over time. I understand that no test is perfect. I understand that despite following the best procedures, and using appropriate equipment and supplies, and through no fault of Discovery Genomics, a test result may be incorrect. I release Discovery Genomics, its affiliates, their employees, officers and agents, and my employer or Purchasing Organization from responsibility for incorrect results from testing that is performed in accordance with approvals by the US FDA (Food and Drug Administration) and relevant regulatory authorities. I authorize Discovery Genomics and its affiliates to use my sample and all derivative works for research and commercial use. If my test results come back as positive, I understand that repeat testing is necessary, in order to confirm a positive result. I understand that an initial negative result does not guarantee that all subsequent results will be negative.

I acknowledge that my consent is valid for the current sample testing and any future sample testing. I acknowledge that I have the right to receive a copy of this authorization. I consent to being approached by Discovery Genomics through email, phone or postal service for participation in clinical research. This consent form supersedes all prior consent forms that I may have signed with regard to the COVID-19 Safety Program.

I acknowledge that I have read this document in its entirety and agree to the above. If under the age of 18, I agree not to participate in this medical exam without the written consent of a parent or legal guardian. I also fully understand the attendant risks and discomforts of this test. All of the information provided herein is true and accurate to the best of my knowledge.

_____ _____ _____
Signature of individual being tested Date of Consent Phone#

_____ _____ _____
Printed Name Date of Birth Email address

_____
Residential Address, City, State, Zip

For Minors:

_____ _____ _____
Parent/guardian signature Date Signed by Parent Parent/Guardian Phone Number

_____ _____ _____
Printed Parent Name Relationship Parent/Guardian address, city, state, zip