COMUSAV COALICIÓN MUNDIAL SALUD Y VIDA	WORLDWIDE COMUSAV HUMAN MEDICINE DIVISION GENERAL DIRECTORATE FOR PLANNING AND EVALUATION GENERAL DIRECTORATE FOR RESEARCH AND DEVELOPMENT		
INFORMED CONSENT FOR MAGNETISM TEST AFTER THE APPLICATION OF ANTI-COVID VACCINES			
Responsible for the document: **General Directorate for Research and Development**	**CODE: MH 01/01/01/01**	**REVISED: O** **10/06/21**	**PAGE: 1 OF 1**

NAME OF PATIENT:	
COUNTRY:	**DATE & TIME:**
DATE OF BIRTH:	**AGE:**
IDENTIFICATION TYPE:	
VACCINE BRAND:	
DATE OF VACCINATION:	**DOIS: 1st 2nd**

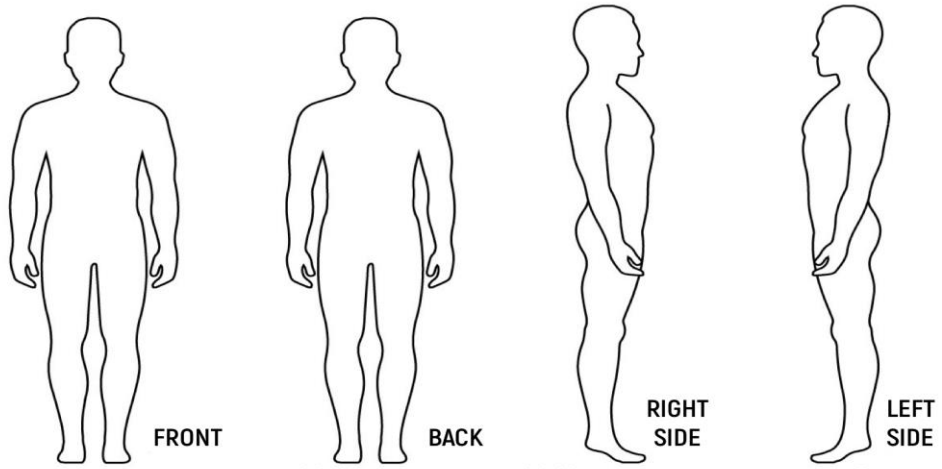
I certify that I have been widely informed by the attending physician about the application of a magnet, as well as the measurement with an electromagnetism reader in different parts of the body, filming such measurements.

It has been explained to me and I have understood that said magnet and reader do not affect in any way the effect and efficacy of the vaccine (s) previously applied.

I express that I have been able to ask all the questions that arose and that they have been answered, having understood the concepts and procedures to be performed.

I authorize Dr. _____ to perform the documentation by photography or digitization, for scientific, academic and educational purposes with the corresponding privacy of my personal data.

Video #_____



I. Magnet Test (+) (-); II. Metal Test (+) (-); III. EMF Reader Test (+) (-)

_____ _____

Physician Name and Signature

Patient Name and Signature