

CONSENT OF PREGNANCY TEST

**PASCUA YAQUI TRIBE
ATHLETIC COMMISSION**

**7777 S. CAMINO HUIVISIM BLDG, C.
TUCSON, ARIZONA 85757**

**PHONE: (520) 883-5114
FAX: (520) 883-5084**

Fighter Name:

Social Security No.:

Driver License No.:

Address:

City:

State:

Zip Code:

I hereby voluntarily submit to a urine sample and authorize and approve the Pascua Yaqui UA lab to test such sample for pregnancy. Such test will be performed by an approved laboratory designated by the Pascua Yaqui Athletic Commission. I hereby consent to the results of said test being released to the Pascua Yaqui Athletic Commission. Since medications can affect test results, I have listed below all medications I have taken during the past ten (10) days (both over-the-counter and prescribed). I understand that failing to supply a urine sample, refusing to submit to a test, tampering with the sample, or falsifying any information obtained in connection with this test will result in an immediate suspension of not less than thirty (30) days, or until such time as a doctor can confirm that I am not pregnant. I also, understand that if the analysis of this urine sample results in a confirmed positive test result I will be prohibited from participating, suspended and civil penalty will be imposed depending on whether I have had any prior confirmed positive test results. I understand that I am entitled to a hearing regarding any disciplinary action taken against me in accordance with Title 14 of the Pascua Yaqui Code. I agree to hold the Pascua Yaqui Tribe Athletic Commission, its agents, directors, officials, and employees harmless from any liability in connection with the pregnancy test conducted. I have noted any perceived irregularities in the collection procedure space provided below:

1) During the past ten (10) days, or at the present time, are you taking?

- Over - the - Counter medications? Yes No
- Prescription medications? Yes No

2) If "YES" to either question, please describe in detail below:

a) Physicians Name:	Address:	City:	State:
Zip Code:	Telephone No.:	Medication Prescribed:	
b) Physicians Name:	Address:	City:	State:
Zip Code:	Telephone No.:	Medication Prescribed:	
c) Physicians Name:	Address:	City:	State:
Zip Code:	Telephone No.:	Medication Prescribed:	

ANY PERCEIVED IRREGULARITIES IN THE COLLECTION MUST BE NOTED BELOW:

- 1)
- 2)
- 3)

SIGNATURE OF FIGHTER

DATE

SIGNATURE OF PASCUA YAQUI UA LAB

DATE

SIGNATURE OF PASCUA YAQUI INSPECTOR

DATE