

Participant ID _____

Informed Voluntary Consent for Medical Intervention

I, _____
(Full Name, Date of Birth)

Registered address, home address (if different from registered address):

_____ give informed voluntary consent to the medical interventions specified in the List of Certain Types of Medical Interventions approved by Order No. 390N of the Ministry of Health and Social Development of the Russian Federation dated 23 April 2012 (hereinafter referred to as the Types of Medical Interventions Included in the List) for receiving medical care.

Such interventions include smear tests for the laboratory testing of biological material. The medical service for laboratory testing of biological material is provided by the Federal Centre for Hygiene and Epidemiology of the Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing. The medical service for collecting biological material for laboratory testing (taking a smear) is provided locally by:

this box should be completed by the organization that collects biological material

The healthcare provider

_____ (*Position, surname, name, patronymic (if any) of the healthcare provider*) has explained to me the objectives, treatment methods, associated risks, available medical interventions, their implications, including possible complications, and the anticipated outcomes of treatment in a manner that I can easily understand. I have been informed that I retain the right to decline specific medical interventions listed or to request that they be stopped, except in cases outlined in Article 20, Part 9 of Federal Law No. 323-FZ 'On the Fundamentals of the Protection of Citizen's Health in the Russian Federation' dated 21 November 2011.

Information about the persons I have selected, in accordance with Article 19, Part 3, Paragraph 5 of Federal Law No. 323-FZ 'On the Fundamentals of the Protection of Citizen's Health in the Russian Federation' dated 21 November 2011, to be informed about my health:

_____ (Full name of selected person, contact number. If unavailable, use a dash)

_____ (Signature)

_____ (Name of healthcare provider)

Date of completion _____ 2026

✓

_____ (Signature)

_____ (Full name)

Participant ID _____

Consent to the Processing of Personal Data

I, _____,
(Full Name, document (passport), series, number, issuing authority, date of issue)
registered at the address:

In accordance with requirements of Federal Law No. 152-FZ 'On Personal Data' dated 27 July 2006, I hereby give my consent to the processing of my personal data by the Federal Centre for Hygiene and Epidemiology of the Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (TIN 7726008570, address: 19A, Varshavskoye Shosse, Moscow, 117105) (hereinafter referred to as the Operator) for the purpose of providing me with medical services and transferring the results of such services to the Roscongress Foundation (TIN 7706412930) at the address 12, Krasnopresnenskaya Naberezhnaya, Entrance 7, Office 1101, Moscow, 123610; LLC 'RC Avangard' (TIN 7801714480), at the address 88, Sredny Ave, building A, room 39N, Office 3, Saint Petersburg, 199106 so that I can participate in an international event.

Such information includes: my surname, first name, patronymic, date of birth, gender, address (including registration information), phone number, identity document details (series, number, date of issue, name, and code of the issuing authority), information on the medical care provided, health status data, including medical history containing private health information, and participant ID number.

I hereby authorize the Operator to perform all actions (operations) or set of actions (operations) when processing my personal data, whether automated or manual, including the collection, recording, systematization, accumulation, storage, clarification (updating, modification), extraction, use, transmission (provision, access), depersonalization, blocking, deletion, and destruction of personal data.

The Operator has the right to process my personal data by entering it into information repositories (electronic databases, lists, registers).

For these purposes, I give my consent to the transfer of my personal data, specifically, information on the results of the medical service provided, including private health information and participant ID number, to the Roscongress Foundation, RC Avangard'. My personal data may be processed, transferred or otherwise disclosed to other persons only with my separate written consent.

I reserve the right to withdraw my consent in writing, which must be sent to the Operator by registered mail with acknowledgement of receipt, or delivered personally and signed for by a representative of the Operator.

This consent is valid until the results of the medical services rendered are processed and transferred to the Roscongress Foundation, RC Avangard'. The period for retaining my personal data in the health records of the Operator complies with the requirements of the laws of the Russian Federation.

Date of completion _____ 2026

✓ _____
(Signature) (Full name)