NYS Donate Life Registry Enrollment Form

*Please Print (*Required Information)*

Prefix _____ (Mr., Mrs,. Ms,. Dr., Fr., etc.)

*First Name _____ Middle Initial ___

*Last Name _____

Suffix _____ (Jr., Sr., II, etc.)

*Address _____

*City _____*State _____ *Zip_____

Phone (_____) _____ – _____

*Date of Birth ____ /____ /____ *Gender ☐ Male ☐ Female

*Height _____feet ____inches *Eye Color _____

*9-digit driver license or non-driver identification (ID) number

____ _____ _____ _____ _____ _____ _____ _____ _____

*I offer the donation of:

☐ All Organs, Tissues and Eyes

☐ Limited Organs, Tissues and Eyes as Specified Below
(Please check the box of the organs and tissues that you wish to donate):

☐ Bone and Connective Tissue
☐ Corneas
☐ Eyes
☐ Heart (for Valves)
☐ Heart with Connective Tissue
☐ Kidneys
☐ Liver/Iliac Vessels
☐ Lungs
☐ Pancreas (with Iliac Vessel)
☐ Skin
☐ Small Intestine
☐ Veins

*I wish to donate the organs and or tissues specified above for:

☐ Transplantation and Research

☐ Transplantation Only

☐ Research Only

I wish to enroll in the New York State Donate Life Organ and Tissue Donor Registry maintained by the State Department of Health. I understand that by enrolling in the registry I am giving legal consent to the donation of my organs tissues and eyes (as specified above) in the event of my death. I authorize the State Department of Health to access this information as needed in administration of the registry, and to share this information at or near the time of my death with federally regulated organ procurement organizations, New York State licensed tissue and eye banks and entities formally approved by the Commissioner.

_____ ____ /____ /____
Signature Date

Mail to: New York Organ Donor Network
460 West 34th Street, 15th Floor
New York, NY 10001