Organ Donation Form

I, ______________________________________________________________________ (Check only 1 of 3 following options.)

1. _____ have recorded my wishes for donation on the donor registry of _______________________________________________________.

OR

2. _____ hereby make the anatomical gifts noted with my initials below, to take effect on my death. (Initial all that apply)
   a. ___ any needed organs for the purpose of
      ___ transplantation
      ___ medical research or education
   b. ___ my eyes for the purpose of
      ___ transplantation
      ___ medical research or education
   c. ___ any needed tissues for the purpose of
      ___ transplantation
      ___ medical research or education
   d. ___ only the following organs and/or tissues for the purpose of transplantation:
      ___________________________________________________________________
   e. ___ only the following organs and/or tissues for the purpose of medical research or education:
      ___________________________________________________________________

OR

3. _____ wish to donate my whole body for anatomical study. Donation of your body for anatomical study means you cannot donate any organs, tissues, eyes or other body parts for transplants, education or research above. To complete a donation of your whole body for anatomical study, you must contact the Anatomical Board of the State of Florida by calling 1-800-628-2594 or 352-392-3588 for further instructions and the appropriate additional forms.

Limitations or special wishes, if any: ______________________________________________________________________________________

_________________________________________________________________________________

Signed by the donor and the following witnesses in the presence of each other, except that Option 1 does not require witnesses to the donor’s signature:

First Witness:  Second Witness:  Donor’s Date of Birth  Date Signed

Donor’s Signature  Donor’s Signature  ____________________________  ____________________________

Signature __________________________ Date __________________ Signature __________________________ Date __________________

Print Name __________________________ Print Name __________________________

Address __________________________________ Address __________________________________

Phone _______ Phone _______

Patient Name:  Patient Identification #:

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