

CONSENT FORM

A A B B DR DR DQ DQ DRw DRw

I am voluntarily furnishing blood to the American Bone Marrow Donor Registry (ABMDR) for the purpose of determining my HLA type for compatibility comparison as a possible marrow or stem cell donor, or I am submitting my HLA type information for recording in the American Bone Marrow Donor Registry files. I understand the need for and the process involved in marrow or stem cell donation. I hereby grant the ABMDR permission to enter my information and HLA type in its files and to include my HLA type only in Bone Marrow Donors Worldwide to be compared to patients' types in this country and worldwide who are viable candidates for marrow transplantation. I further understand that part of my blood sample may be stored for the sole purpose of conducting further testing if I am determined to be a possible match with a patient. I understand that such testing would not be performed without my signed consent. I further understand that my name will be kept confidential and not released without my written permission. I understand that the only side effects from the sample collection might be some bruising or redness at the site of the needle insertion.

Donor Name (Please Print) _____ Date ____/____/____

Donor Signature _____ Witness Signature _____

Donor Information (Confidential)

Street Address _____ Apt.# _____

City _____ State _____ Zip _____

Phone Home (_____) _____ Work\Cell (_____) _____

Fax(_____) _____ Email: _____

D.O.B. ____/____/____ Sex _____ Spouse First Name _____

Driver's License: State (_____) _____ SS# _____

Above information used only for the purpose of locating a donors' forwarding address or for cross-checking donor records.

Ethnic origin: (may help in patient/donor matching due to the frequent occurrence of some HLA antigens within certain ethnic groups.)

____ Caucasian ____ African American ____ Native American ____ Asian ____ Hispanic/Latino

Other (specify) _____ Specific heritage (e.g French, Jewish, Korean) _____

Name and address of a relative or close friend who could contact you if we are unable to reach you.

Name _____ Spouse name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Phone Home(____) _____ Work\Cell (____) _____

If you are related to a particular patient, please note relationship and name

Patient Name: _____ Relationship _____

Donor Drive:(if applicable) _____