**Organ Donor Registry Enrollment Form**

*Denotes required information (please print)*

**PERSONAL INFORMATION**

Prefix __ __ __(Mr., Mrs., Dr., etc.)

*First Name __ __ __ __ __ __ __ __ __ __ __ __  __  Middle Initial __

*Last Name __ __ __ __ __ __ __ __ __ __ __ __ __   Suffix __ __ __(Jr., Sr., II, etc.)

*Address __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

*City __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ _ *State __ __ *Zip __ __ __ __ __

Phone (__ __ __) __ __ __ - __ __ __ __

Email address __ __ __ __ __ __ __ __ __ __ __ __ __

*Date of Birth __ / __ / __

*Gender          M        F

*Height   __ Feet __ __ Inches

*Eye Color __ __ __ __ __

9-Digit Driver License or Non-Driver ID Number (not required) __ __ __ __ __ __ __ __ __

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**SPECIFICATIONS**  
(Please complete Part 1 and Part 2)

*Part 1:

☐ I consent to the donation of all my organs, tissues and eyes

OR

☐ I consent to the donation of only the organs and tissues checked below:

<table>
<thead>
<tr>
<th>Organs</th>
<th>Tissues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>Blood vessels</td>
</tr>
<tr>
<td>Intestines</td>
<td>Bone and Connective Tissue</td>
</tr>
<tr>
<td>Kidneys</td>
<td>Corneas</td>
</tr>
<tr>
<td>Liver</td>
<td>Eyes</td>
</tr>
<tr>
<td>Lungs</td>
<td>Skin</td>
</tr>
<tr>
<td>Pancreas</td>
<td></td>
</tr>
</tbody>
</table>

*Part 2:

I consent to donate my organs and/or tissues for the purpose(s) of:

☐ Transplant and Research

☐ Transplant Only

☐ Research Only

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**SIGN & DATE**

By signing below, I am indicating my consent to enroll in the New York State Donate Life Organ and Tissue Donor Registry. 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 access to this information as needed for the administration of the registry, and to federally regulated organ procurement organizations, New York State licensed tissue and eye banks, and entities formally approved by the NYS Commissioner of Health at or near the time of my death.

________________________________________________  ___ /___ /___

*Signature

*Date

Team: _____________________________________________________

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Mail to: LiveOnNY | 460 W 34th St, 15th Fl | NY, NY 10001

www.LiveOnNY.org

An incomplete form, is a wasted form – it can’t be used!

Make your generous act count. Fill out all *required information!