



Donor Registration Form

To register as a donor, please complete this form and submit by mail or fax to **Donate Life Texas**.

If you have any questions, contact: **(214) 443-4255**

mail:

Donate Life Texas
8190 Manderville Ln
Dallas, TX 75231

fax:

(713) 349-2588 or
(210) 614-2129

NAME (please print)		
First Name	M.I.	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

GENDER	BIRTH DETAILS	
Male <input type="checkbox"/>	Place of Birth (city, state, country)	Date of Birth (month/day/year)
Female <input type="checkbox"/>	<input type="text"/>	<input type="text"/>

CONTACT INFORMATION (please print)			ETHNICITY (optional)	
Address Line 1 (street address, p.o. box, c/o)			Alaska Native / Native American	<input type="checkbox"/>
Address Line 2 (apartment, suite, unit, building, floor, etc.)			Asian	<input type="checkbox"/>
City	State	Zip	Black / African American	<input type="checkbox"/>
Phone	Email		Hispanic / Latino	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>		Native Hawaiian / Other Pacific Islander	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>		White / Caucasian	<input type="checkbox"/>

IDENTIFICATION (please provide one)			
Last 4 digits of SSN	<input type="text"/>	Texas ID Card No.	<input type="text"/>
Texas Driver's License No.	<input type="text"/>	Mother's Maiden Name	<input type="text"/>

WHAT YOU ARE DONATING (select one)	
All organs and tissues	<input type="checkbox"/>
Specific organs and tissues	<input type="checkbox"/>

WHAT YOU ARE DONATING FOR (select one)	
Transplantation, research, or education purposes	<input type="checkbox"/>
Transplantation only	<input type="checkbox"/>

If you selected to donate **specific organs and tissues**, please indicate below what you would be willing to donate:

ORGAN(S) (optional)		TISSUE(S) (optional)		EYE(S) (optional)	
Heart <input type="checkbox"/>	Kidneys <input type="checkbox"/>	Heart Valves, Vessels, Pericardium <input type="checkbox"/>	Bones <input type="checkbox"/>	Eyes <input type="checkbox"/>	
Lungs <input type="checkbox"/>	Pancreas <input type="checkbox"/>	Arteries <input type="checkbox"/>	Skin <input type="checkbox"/>	Corneas <input type="checkbox"/>	
Liver <input type="checkbox"/>	Small Intestine <input type="checkbox"/>	Veins <input type="checkbox"/>	Soft Tissues <input type="checkbox"/>		

AUTHORIZATION	
Signature	Date (month/day/year)
<input type="text"/>	<input type="text"/>