BRAIN AND TISSUE BANK FOR DEVELOPMENTAL DISORDERS
University of Maryland, Baltimore
(410)-706-1755 (800)-847-1539 FAX: (410)-706-0020

DONOR REGISTRATION FORM

I, _____ wish to register myself (or a dependent minor) as a tissue donor with the ***Brain and Tissue Bank for Developmental Disorders*** at the University of Maryland, Baltimore. Completion of this registration form provides important information needed to coordinate tissue recovery in the event of the death of the donor. After the ***Brain and Tissue Bank*** receives this registration form, you will receive a packet containing Anatomical Gift Act forms and Access to Medical Records forms and other materials.

(Please complete both Part One and Part Two.)

DONOR INFORMATION (Part One)

FULL NAME _____DATE OF BIRTH _____
STREET ADDRESS (1) _____
STREET ADDRESS (2) _____
CITY _____ STATE _____ ZIP CODE _____
PHONE (Day) _____ PHONE (Evening) _____

IF THE DONOR WAS DIAGNOSED WITH A DISORDER, PLEASE COMPLETE THE FOLLOWING

NAME OF DISORDER _____
DIAGNOSED WHEN (Date) _____
DIAGNOSED BY (Name of physician/lab)_____
ADDRESS: _____
CITY _____ STATE _____ ZIP CODE _____
IF KNOWN, WHAT SPECIFIC TEST(S) OR CLINICAL FINDINGS CONFIRMED THE DIAGNOSIS?
_____
_____

PLEASE PROVIDE A BRIEF MEDICAL/FAMILY HISTORY
(Please continue on reverse side if additional space is needed.)

_____
_____
_____
_____
_____
_____

NEXT OF KIN INFORMATION (Part Two)

FULL NAME _____
RELATIONSHIP TO DONOR _____
STREET ADDRESS_____
CITY _____ STATE _____ ZIP CODE _____
PHONE (Day) _____ PHONE (Evening) _____FAX _____