



# Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

## NYS Donate Life Organ and Tissue Donor Registry Enrollment Form

**Please Print** ( \* required )

Prefix: \_\_\_\_\_ (Dr., Fr., etc)

\*First Name: \_\_\_\_\_

Middle Init: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_ (Jr, Sr, II, etc)

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Gender: \_\_\_\_ Male \_\_\_\_ Female

\*Height: \_\_\_\_ feet \_\_\_\_ inches \*Eye Color: \_\_\_\_\_

9- digit Motor Vehicle license or non-driver license DMV issued ID number: \_\_\_\_\_

\* I offer the donation of:

- All Organs, Tissues and Eyes
- Limited Organs, Tissues and Eyes as specified below

Please CHECK the box of the organs and tissues that YOU WISH TO DONATE:

- |   |   |
|---|---|
| <input type="checkbox"/> Bone and Connective Tissue   | <input type="checkbox"/> Liver/Iliac Vessels          |
| <input type="checkbox"/> Corneas                      | <input type="checkbox"/> Lungs                        |
| <input type="checkbox"/> Eyes                         | <input type="checkbox"/> Pancreas (with Iliac Vessel) |
| <input type="checkbox"/> Heart (For Valves)           | <input type="checkbox"/> Skin                         |
| <input type="checkbox"/> Heart with Connective Tissue | <input type="checkbox"/> Small Intestine              |
| <input type="checkbox"/> Kidneys                      | <input type="checkbox"/> Veins                        |

\* I wish to donate the organs and or tissues specified above for:

- Transplantation and Research
- Transplantation only
- Research only

I wish to enroll in the New York State Donate Life Organ and Tissue Donor Registry maintained by the State Department of Health. 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 the State Department of Health to access this information as needed in administration of the registry, and to share this information at or near the time of my death with federally regulated organ procurement organizations, New York State licensed tissue and eye banks and entities formally approved by the Commissioner.

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Mail to: **New York State Donate Life Organ and Tissue Donor Registry**  
**NYS Department of Health**  
**875 Central Avenue**  
**Albany, NY 12206**