

Enrollment Form



To register, please complete and mail this form to:

**NY Organ Donor Network
132 W. 31st St., 11th Floor
New York, NY 10001**

Please print

Date _____/_____/_____

9-digit Motor Vehicle license or non-driver license ID number

Last name

First name

Middle Initial

_____/_____/_____ Eye Color _____

Date of Birth

Sex: ___ Male ___ Female Height: _____ Feet _____ Inches

Address

City

State

Zip

I wish to be listed in the New York State Organ and Tissue Donor Registry maintained by the state Department of Health to record my intent to donate my organs and tissues in the event of my death. I authorize the state Department of Health to share this information with federally regulated organ procurement organizations and New York State-licensed tissue banks and hospitals at the time of my death.

Signature: