Fort Worth Eye Bank 1400 S. Main, Ste. 205 Fort Worth, Texas 76104 (817) 334-7900 **CONSENT FOR EYE AND TISSUE DONATION (1P)**	Donor Name: ______________________________ ME/PA #: ________________________________ Donor #: _________________________________

I, ____(donor)

born on __________________________ (donor's DOB) and who resides at ______

____(donor's street address)

____ (donor's city, state, zip code)

hereby donate the following tissues in accordance with the Texas Anatomical Gift Act:

Eyes (cornea and sclera) _____ Corneas only ____

I am aware of no contrary indication for the donation of these tissues or any opposition by those members of my immediate family who will be considered survivors after my death.

I understand that these tissues may be used for any lawful purpose including transplantation, training, therapy, or research. I also understand that any of the tissues may be used by Fort Worth Eye Bank, or may, without further consent or notice, be recovered by another institution for transplantation, training, therapy, or research.

I consent to any appropriate testing regarding the suitability of donor tissues for donation. I also give permission for the release of any protected health information pertinent to the evaluation or follow-up of the donated tissues.

I understand that I will incur no expense for the retrieval of donated tissues. I also understand that I will receive no compensation for any donated tissues.

Furthermore, I understand that neither Fort Worth Eye Bank or the Willed Body Program at the University of North Texas Health Science Center at Fort Worth is affiliated, but give consent for the removal of whole eyes or corneas (as determined above) for transplantation, training, therapy, or research purposes in association with this Whole Body Donation.

❑ Recorded Telephonic Consent (Tape #____________)

______________________________	______________________________
Printed Name of Donor	Donor Telephone Number
______________________________	______________________________
Signature of Donor	Date/Time
______________________________	______________________________
Witness Signature	Date/Time

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