

DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

(name of donor)

INSTRUCTIONS: In addition to completing the references to Anatomical Gifts in your Living Will and Ohio Health Care Power of Attorney you should also complete and file the “Donor Registry Enrollment Form” with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

To register for the Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles
ATTN: Record Clearance Unit
P.O. Box 16784
Columbus, Ohio 43216-6784

Make a copy of this form and retain it as part of your Living Will Declaration.

[This form must be signed by two witnesses. If the donor is under the age of 18, a parent or legal guardian must sign as one of the two witnesses.]

[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]

Please indicate below:

Please include me in the Donor Registry

Please remove me from the Donor Registry



Print or type full name of living donor _____

Mailing Address _____

City _____ State _____ Zip _____

Phone () _____ Date of Birth _____

Driver's License or ID Card Number _____

Social Security Number _____

In the hope that I, _____ (name of donor), may help others upon my death, the following are my directions regarding donation of all or part of my body.

___ On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OR

___ On my death, I make an anatomical gift of the following specified organ, tissues, or eyes for any purposes indicated below:

- | | | | |
|-------------------------------------|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Any or all | <input type="checkbox"/> Liver | <input type="checkbox"/> Bone/ligament | <input type="checkbox"/> Heart valves |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Veins | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Eyes | <input type="checkbox"/> Other |

Any purpose authorized by law or, specifically as indicated below:

- Transplantation
- Therapy
- Research
- Education
- Advancement of medical science
- Advancement of dental science

Signature of Donor

Date of Birth of Donor _____ Date Signed

Witness _____ Date

Witness _____ Date