Wisconsin Donor Registry Enrollment

YES! I want to help save lives through organ, tissue and eye donation.

To include your name in the Registry, complete the form below. It is important to enter your information exactly as it appears on your Wisconsin driver's license or State identification card. All information is strictly confidential and is only available to organ and tissue recovery organizations at or near the time of your death. Donation professionals will present documentation of your inclusion in the Registry to your family and work with them to honor that decision.

First Name _____

Middle Name _____

Last Name _____

Birth Date _____ Gender _____

WI Driver's License or State ID Number _____

Address 1 _____

Address 2 _____

City, State, Zip _____

County _____

Before you register, please understand the following:

- Being a donor improves the lives of others through transplantation, therapy, research and education
- You may register if you are over age 15 ½ and have a Wisconsin driver's license, permit or identification card
- Your name included on the Registry means you have authorized the gift of your organs, tissues and eyes upon your death
- Once you register as a donor, you have made a record of an anatomical gift in accordance with Wisconsin state law
- If you are at least 18 years old, your decision may not be overridden by your family or any other person

By submitting this registration I affirm that I am the applicant described on this application and that the information entered herein is true and correct to the best of my knowledge. This registration will serve as a record of gift in accordance with Wisconsin state law. A record of gift, not revoked by the donor before death, does not require the consent of any other person. It also authorizes any examination necessary to ensure the medical acceptability of the anatomical gift.

☐ I wish to donate my organs, tissues, and eyes for transplantation, therapy, research and education.

☐ By signing this form I agree to the above mentioned terms and conditions.

Signature _____ Date _____

OPTIONAL INFORMATION:

Did information from any of these areas influence your decision to register? *(Select all that apply)*

☐ School ☐ Media ☐ Religious Organization ☐ Work ☐ DMV

☐ Clinic/Pharmacy ☐ Family/Friends ☐ Other _____

Phone _____

Email _____

Please return the completed form and direct any questions to:

Wisconsin Department of Health Services
Division of Public Health, **Attn: Martha Mallon**
1 W. Wilson Street, Rm. 218
PO Box 2659
Madison, WI 53701-2659

Reset Form

F-02051 (03/2017)

PROUD MEMBER
DONATE LIFE Wisconsin