# Dr. K. K. Surgical & Peadiatric Centre

## DONATE YOUR EYES LIVE TWICE

### EYE DONATION FORM

(Authority by Donor for removal of eyes)

I, _____son/daughter/wife of
_____ aged _____ years,
residing at _____
hereby express my free and frank consent for the removal of my eyes after my death from my body, by a registered medical practitioner (Ophthalmic) of a recognized Eye Bank / Hospital for their use for therapeutic purposes. I have been explained and I understand all the aspect of such a donation.

Place _____ Signature _____

Date _____ Time_____ AM/PM

1. Witness (Next of kin)
Signature
_____
Name
_____
Relationship
_____
Address
_____
Telephone No., if any
_____

Name of the nearest hospital
_____

Name of the family physician, if any
_____

*for official use only*
Donor Card No. _____
Dated_____