FOUNDATION FIGHTING BLINDNESS
RARE EYE DONOR PROGRAM REGISTRATION FORM

Complete form, then sign and mail to:

Foundation Fighting Blindness
7168 Columbia Gateway Drive, Suite 100
Columbia, MD 21046

NOTE: An organ donor card obtained through the Department of Motor Vehicles may ***not*** substitute for a Foundation Eye Donor Card.

Name (Print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Birth Date: _____ Sex: M F

Most recent eye doctor:
Name: _____

City/State: _____ Phone: (____)_____

Check all that apply:
☐ I have a retinal degenerative disease.
☐ I have a blood relative who has a retinal degenerative disease.
State person's relationship to you: _____

Name of Retinal Disease:

☐ Retinitis Pigmentosa	☐ Atypical Retinitis Pigmentosa
☐ Usher syndrome	☐ Stargardt disease
☐ Leber Congenital Amaurosis	☐ Choroideremia
☐ Bardet-Biedl syndrome	☐ Best (Vitelliform Dystrophy)
☐ Gyrate atrophy	☐ Juvenile inherited macular dystrophy

☐ Age-related macular degeneration: Type? Wet Dry Unknown
☐ Other _____

So that others may see, I hereby make this anatomical gift to the Foundation Fighting Blindness. After my death, I give my eyes, at no cost to my family or estate, for medical research or education. I authorize release of my medical records for research purposes. **ALL SIGNATURES REQUIRED.**

_____ _____
Signature of Donor (parent or guardian if under 18) Date

_____ _____
Witness 1 Date

_____ _____
Witness 2 Date

_____ _____
Next of Kin (may also be witness) Date