GENERAL INFORMATION SHEET

Donor Information **Full Name** _____
Last First Middle Maiden Name

Also Known As (AKA), if any _____
Last First Middle Maiden Name

Residence Address: _____ **County** _____
Street Address Apt # P O Box City/Municipality State Zip Code

If your residence lies within a *Township, list the Township* _____ **County** _____
Name of Township

Telephone (_____)_____-_____ **Social Security Number** _____-_____-_____ **Sex ☐ M ☐ F**
Area Code

Date of Birth ____/____/_____ **Place of Birth** _____
City & State OR City & Foreign Country

Education: ***(Highest degree or level of school completed at time of death)***

☐ *Grade 8 or less* ☐ *Grade 9-12, no diploma* ☐ *High School graduate or GED*

☐ *Some college credit, no degree* ☐ *Associate degree (AA, AS)* ☐ *Bachelor's degree (BA, AB, BS)*

☐ *Master's degree (MA, MS, MEd, MSW)* ☐ *Doctorate (PhD, EdD or Professional degree (MD, DDS, JD)*

Race: ☐ *White* ☐ *Black or African American* ☐ *American Indian or Alaska Native (Enrolled or principle tribe)*_____

☐ *Asian Indian* ☐ *Filipino* ☐ *Korean* ☐ *Chinese* ☐ *Japanese* ☐ *Vietnamese*

☐ *Other Asian (Specify)* _____ ☐ *Native Hawaiian* ☐ *Guamanian or Chamorro*

☐ *Samoan* ☐ *Other Pacific Islander (Specify)* _____ ☐ *Other (Specify)*_____

Of Hispanic origin? ☐ **YES** ☐ **NO** - ***If YES,* specify** ☐ *Yes, Mexican, Mexican American, Chicano*

☐ *Yes, Puerto Rican* ☐ *Yes, Cuban* ☐ *Yes, Other Spanish/Hispanic/Latino* **(Specify)** _____

U.S. Armed Forces ☐ **YES** ☐ **NO** ***If YES,* from** _____**to**_____ **Name War/Conflict** _____

Employment **-** ***if Retired (list past employment):***
List PRIMARY lifetime occupation _____ **In what kind of business or Industry** _____

Name and Address of this PRIMARY employer _____
Name, Address, City and State

PLEASE TURN FORM OVER AND COMPLETE OTHER SIDE →→→→→→→→

Current Marital Status:

Please check ONE option: ☐ Single/Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Only if currently Married

Name of Spouse/Partner *(Maiden name should be name given at birth or on Birth Certificate)*

_____

Last First Middle Maiden Name

Are you Presently Registered in a Domestic Partnership ☐ Yes ☐ No

Are you Presently Registered in a Civil Union Partnership ☐ Yes ☐ No

Parent Information – *LIST EVEN IF DECEASED*, PLEASE LIST all information requested

Father's Name _____

Last First Middle

Mother's Name, *w/Maiden name* _____

Last First Middle Maiden Name

Secondary Contact Person **-**
other than the person listed on your Bequeathal Form

_____

Last First Relationship to Donor

Complete Address and phone _____ ( )

Street Address City State Zip Area Code Telephone

Signature of Secondary Contact: _____ Date: _____

Medical Questions

Stature: Height _____ Weight _____ Do you presently have a pacemaker? ☐ YES ☐ NO

***If FEMALE*, have you had a hysterectomy? ☐ YES ☐ NO**

Do you have or have had any Radioactive Implants? ☐ YES ☐ NO If Yes, what year? _____

Please indicate below if you have had or suffered from any of the following:

☐ HIV-AIDS ☐ Coronavirus ☐ Hepatitis B ☐ Hepatitis C ☐ Creutzfeldt-Jakob Disease ☐ MRSA ☐ *C-Diff* ☐ Tuberculosis
☐ Smallpox ☐ Anthrax ☐ Rabies ☐ Malaria ☐ Meningococcal Disease ☐ Plague ☐ Syphilis ☐ Q Fever ☐ Yellow Fever
☐ Typhoid Fever ☐ Viral Hemorrhagic Fevers ☐ Toxoplasmosis Disseminated ☐ Adenovirus ☐ *E-coli*

Miscellaneous **When our medical school holds its annual memorial service, would you welcome an invitation to your family? ☐ YES ☐ NO**

RETURN THIS FORM WITH BEQUEATHAL FORM