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 __________________________ 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

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

If any are checked above, please indicate date(s) of diagnosis___________________________________________

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

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: ___________________

RETURN THIS FORM WITH BEQUEATHAL FORM 5/2022