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	
	O Box City/Mu	nicipality Stat	e Zip Code	_ county _	
If your residence lies within a <u>Townsh</u>	<u>ip,</u> list the Town	nshipName	of Township	_ County	
Telephone ()	_ Social Securi	ity Number	<u> </u>		Sex □M □F
Date of Place of					
Birth/ Birth	a Guaran OR Gu	y & Foreign Country			
Cit	ly & State OK Cit	y & Foreign Country			
Education: (Highest degree or level of	school complet	ed at time of death	<u>(1)</u>		
\Box Grade 8 or less \Box Grade 9-12,	no diploma	☐ High School §	graduate or GE	E D	
☐ Some college credit, no degree	□ Associate de	egree (AA, AS)	□ Back	helor's degr	ee (BA, AB, BS)
☐ Master's degree (MA, MS, MEd, MS	$(SW) \qquad \Box \ Doc$	torate (PhD, EdD	or Professiona	al degree (M	ID, DDS, JD)
Race:	n American	American India (Enrolled or pri			
□ Asian Indian □ Filipino	□ Korean	□ Chinese	□ Japanese	□ Vietnam	ese
☐ Other Asian (Specify)		□ Nativ	e Hawaiian	□ Guaman	iian or Chamorr
☐ Samoan ☐ Other Pacific Island	er (Specify)		Othe	er (Specify)_	
Of Hispanic origin? □YES □NO · □ Yes, Puerto Rican □ Yes,		Yes, Mexican Other Spanish/H			
U.S. Armed Forces	If YES, from _	to	Name	e War/Conf	lict
Employment - <u>if Retired (list past employment):</u> List PRIMARY lifetime occupation		In what kind of business or Industry			
Name and Address of this PRIMARY employer	Name, Address, Cit	ty and State			

Parent Information – <u>LIST EVEN IF DECEASED</u> , PLEASE LIST all information requested Father's Name Last First Middle Mother's Name, w/Maiden name Last First Middle Maiden Name	<u>Current Marital Statu</u> Please check ONE op		/Never Married □ Ma	arried 🗆 Widowed	☐ Divorced ☐ Separated
Last First Middle Malden Name	Only if currently Mar	<u>ried</u>			
Are you Presently Registered in a Domestic Partnership	Name of Spouse/Part	ner (Maiden nam	e should be name give	n at birth or on Birth	Certificate)
Are you Presently Registered in a Civil Union Partnership		Last	First	Middle	Maiden Name
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 Onestions Stature: Height 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 Tuberculos 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 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	Are you Presently Re	egistered in a Don	nestic Partnership	□ Yes	□ No
Last First Middle	Are you Presently Registered in a Civil Union Partnership			□ Yes	□ No
Mother's Name, w/Maiden name Last First Middle Maiden Name	Parent Information -	- <u>LIST EVEN IF</u>	<u>DECEASED</u> , PLEAS	E LIST all information	on requested
Last First Middle Maiden Name	Father's Name	Last	First	Middle	
Medical Questions Stature: Height Do you presently have a pacemaker? YES NO	Mother's Name, w/M	aiden name	Last First	Middle	Maiden Name
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 Tuberculos 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 No Secondary Contact Person First Relationship to Donor					pacemaker? 🗆 YES 🗆 NO
☐ HIV-AIDS Coronavirus ☐ Hepatitis B ☐ Hepatitis C ☐ Creutzfeldt-Jakob Disease ☐ MRSA ☐ C-Diff ☐ Tuberculos ☐ 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	Do you have or have ha	nd any Radioactive	Implants? □YES □	NO If Yes, wha	nt year?
would you welcome an invitation to your family?	□ HIV-AIDS □ Corona □ Smallpox □ Anthrax □ Typhoid Fever □ Vir	virus □ Hepatitis E □ Rabies □ Malar al Hemorrhagic Fev	B ☐ Hepatitis C ☐ Creut ia ☐ Meningococcal Dis ers ☐ Toxoplasmosis Di	zfeldt-Jakob Disease ease Plague Syph sseminated Adenovir	ilis 🗆 Q Fever 🗆 Yellow Fever
Last First Relationship to Donor Complete Address and phone ()	<u>Miscellaneous</u>				
Complete Address ()	other than the person li	isted			
and phone ()	Last		First	Relationship to	Donor
Street Address City State Zip Àrea Code Telephone					()
	r	Street Address	City	State Zip	Àrea Code Telephone