Form 1(Rule 3)

Ph. (+91-11)-6864851-65
Ext. 3060, 3062

National Eye Bank

(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 ________________

2. Witness

Signature ___________________________

Name _____________________________

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 ________________________________