Carter BloodCare

HEREDITARY HEMOCHROMATOSIS DONATIONS ACKNOWLEDGEMENT

I understand that as a person with a diagnosis of hereditary hemochromatosis (HH), I am eligible for a program at Carter BloodCare that allows me to donate blood, which may contribute to the treatment of my condition, without payment for the procedure.

I understand that participation in this program does not depend on my ability to qualify for the volunteer donor pool. In other words, no matter what my health history answers are to the donor questionnaire, my blood will be drawn at no cost to me.

Printed Name: _____ Date of Birth: _____

Address:

_____ _____ _____ _____
Address City State Zip Code

Phone: Email Address:

(_____)_____ _____
Area Code Phone Number

Please Initial 1 of the Options Below:

_____ Yes, I would like my blood to be made available for transfusion to patients, if I meet all the current eligibility criteria. (I have reviewed the donor criteria pages and believe I qualify).

_____ No, I do not want my blood to be made available for use. (I understand I will still be drawn at no charge).

_____ _____
Signature Date

Please return completed form to:

Donor Notification Department
Email: DN@carterbloodcare.org
FAX: 817-412-5609