DONOR'S HISTORY

Your Name: _____
First MI Last

Your Maiden Name (If Applicable) _____ Date of birth: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Current Phone Number: _____

Height: _____ Weight: _____

Do you have any preexisting conditions/health problems (if so, please list them below)? ____ Yes ____ No

_____

_____

Surgical History: _____

_____

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Father's Name: _____ Mother's Name: _____

Surviving Spouse: _____
(If Wife, Give Maiden Name) First MI Last

Names (And Ages If Under 18) of Your Living Children: _____

_____

Person to contact after your death (**REQUIRED**):

Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please give an alternate contact (**REQUIRED**):

Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please return this form to:

WWAMI Medical Education Program
Washington State University
Box 643510
Pullman, WA 99164-3510
(509) 335-2602