SHRADDHA EYE BANK

(NETHRADHAMA SUPERSPECIALITY EYE HOSPITAL)

256/14, Kanakapura Main Road, 7th Block, Jayanagar, Bangalore - 560 082.

Ph : 080-2663 4200 Fax : 2663 3770 Website : www.nethradhama.org

EYE PLEDGE FORM

I _____ son/daughter/wife of _____ aged _____ years, residing at _____ _____ Phone : _____

here by 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 the purposes of transplantation, therapy, medical research or education in accordance wih the practices and procedures of the Eye Bank. I have been explained and have understood all the aspects of such a donation.

Date _____

Time _____ AM/PM

Place _____

Signature of the Donor _____

1. _____
(Signature of the Witness)

_____
(Name of the Witness)

_____
(Relationship)

Address _____

_____

_____

_____

2. _____
(Signature of the Witness)

_____
(Name of the Witness)

_____
(Relationship)

Address _____

_____

_____

_____

For Office use only

Name of the nearest Hospital :

Name of the physician if any :