



Department Of Health & Family

**Health & Family Welfare Department of
Govt. of NCT of Delhi**

FORM 1

**FOR EYE DONATION FROM IDENTIFIED LIVING NEAR-RELATED
DONOR**

(To be completed by him or her)
(Refer rules 3 and 5(3)(a))

(To be affixed
here.)

Pledge Form:- On submitting this form you accept that you have willingly given the consent to donate your eyes after your death to any eye bank in Bharat through this form. Your eyes can be used for transplantation or research. इस फॉर्म की जमा करने पर आप स्वीकार करते हैं कि आपने सोच्छा से इस फॉर्म के माध्यम से भारत के किसी भी नेत्र बैंक की आपकी मृत्यु के बाद अपनी आँखें दान करने की सहमति दी है। आपकी आँखें प्रत्यारोपण या अनुसंधान के लिए उपयोग की जा सकती हैं।

Donor Details:-

Donor Name* (Full Name).....

Father/Husband Name*

Blood Group*

Aadhar Card Number*

Mother Name*

Email*

Mobile Number*

Pledge Details:-

Organs (you wish to donate)* Eyes



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Tissues (you wish to donate)* Cornea

Country* India

State*

City*

Landmark

Pin Code*

Emergency Contact Details:-

Emergency Contact Name

Enter Emergency Contact Number

Relation *

Member to be Notified:-

Name Enter Member.....

Member Mobile Number.....

Member Relation

Name of Individual/NGO/Institution who motivated you to pledge: