**CONTACT DETAILS DONOR CENTER**

*Address of donor center:*

*Doctor’s surname and first name:*

**DONOR DETAILS**

*Donor’s surname and first name:*

*Date of birth: Blood group (if known):*

*National register number/Identity card number: Ethnicity:*

*Donor's full address:*

*Donor’s contact details:*

*Tel. (home):……………………………. Tel. (work): …………………………………………….*

*Mobile:*

*E-mail:*

Your signature below confirms that you have read this document. Please indicate whether you agree or disagree with each of the statements.

|  |  |  |
| --- | --- | --- |
| I am still a candidate to voluntarily donate stem and wish to continue being registered in the bone marrow registry. | YES | NO |
| I have understood the information and have received satisfactory answers to my questions. | YES | NO |
| I am prepared to give additional blood samples in the context of a voluntary stem cell donation. The tests requested will be decided by the transplant center of the recipient. | YES | NO |
| I know that the typing will be treated as confidential. | YES | NO |
| This consent form is given voluntarily and deliberately, after having been informed. | YES | NO |
| Together with the doctor, I will complete a medical questionnaire to re-assess my physical suitability as a donor. | YES | NO |
| I confirm that all information in the consent form for registration in the registry of voluntary unrelated stem cell donors is unchanged:   * If not: explanation:   ……………………………………………………………………………… | YES | NO |

You also acknowledge through this document that you have read and understood the data policy applicable to the processing of your personal data in respect of your donation of stem cells from blood or bone marrow, and that you are aware that your personal data will be passed on in encrypted form to the World Marrow Donor Association and other foreign centres active in the field of stem cell transplants. You may register your preferences with regard to the processing of your personal data below.

I do **not** wish to be invited for additional research or innovative medical purposes such as regenerative medicine & immunotherapy.

I do **not** wish to be contacted for the donation of blood, platelets and/or plasma that may be required for the treatment of a specific patient.

I hereby declare that I have read this document and received sufficient information:

I have received a copy of the general donor information sheet, including the data policy, and I have read and understood its contents.

I have received a copy of the information letter about donor expenses and anonymous communication.

I have received a copy of this consent form.

|  |  |
| --- | --- |
| *Surname and first name of the* ***donor****:* | |
| *Signature:* | *Place:*  *Date:* |

I hereby declare that:

the identity of the donor has been verified.

|  |  |
| --- | --- |
| *Surname and first name of the* ***doctor****:* | |
| *Signature:* | *Place:*  *Date:* |

Completed in 2 originals:

* 1 for the candidate donor
* 1 for the records