# vydehi

INSTITUTE OF MEDICAL SCIENCES AND RESEARCH CENTRE

EYE PLEDGE FORM

VYDEHI INSTITUTE OF MEDICAL SCIENCES AND RESEARCH CENTER , BANGALORE

(Authority by Donor for removal of eyes)

I, ______________________________ son/daughter/wife of ______________________________ aged ________ years, residing at ______________________________

hereby 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 their use for therapeutic and research purposes. I have been explained and I understand all the aspect of such a donation.

Signature ____________

Place ____________

Time ______ AM/PM

Date ____________

1. Witness (Next of kin)

Signature ____________

Name ____________

Relationship ____________

Address ____________

Telephone No., if any ____________

2. Witness

Signature ____________

Name ____________

Relationship ____________

Address ____________

Telephone No., if any ____________

Name of the nearest hospital ______________________________

Name of the family physician, if any ______________________________

for official use only Donor Card No . ____________ Dated ____________

Contact number : +91/080-49069000 EXTN NO 1. 1135
2. 1195
3. 1365

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