CORD BLOOD COLLECTION FORM

DESIGNATION REQUEST FORM

FOR FAMILY USE ONLY

Please complete this form and forward to:

Expected Due Date: ______________________

National Children's Leukemia Foundation
7316 Avenue U, Brooklyn, NY 11234
718-251-1222 1-800-GIVEHOPE Fax:718-251-1444

(Please print all information)

Mother's Name: ____SS#____

Address: ____

City: ________________________State: _______________ Zip:____________Phone:_____________________________

Date of Birth:__________________Age:________Race:________________Fax:____________________________________

Family member to contact if you cannot be reached: Name: _______________________Phone______________

NEWBORN INFORMATION: (must be filled in within 30 days of birth)

Name:____________________________ Date of Birth:________ Sex: Male Female

Medical Status: ____

Hospital Chief of Obstetrics:________________________Phone:________________Fax:__________________

HEALTH CARE INFORMATION:

Hospital Name:__________________________Hospital Address:______________________________Phone:____________

Attending Physician:____________________________________Phone:_____________ Fax:_____________

Address:____

Comments:____

INSURANCE

Insurance Carrier:______________________________Subscriber Name____________________________________

Address:____

ID#__________________________________Group #____

I understand that the cord blood collected at time of delivery will be processed and stored long term. I understand that NCLF has no obligation whatsoever if the cells are infected or damaged. (A test will be made before use). NCLF does not guarantee success of any future use of the cells. I waive any dispute with NCLF.

Mother's Signature: **X**_____________________________

(Requests must be signed)