

**DOD BONE MARROW DONOR PROGRAM
DONOR INFORMATION AND HEALTH SCREENING**

Privacy Act Statement

AUTHORITY: 10 USC §36; EO 9397.

PRINCIPAL PURPOSE(S): To solicit personal and medical history information from potential donors to determine eligibility for inclusion in the National Marrow Donor Program Registry.

ROUTINE USE(S): If you are accepted as a donor, your name, Social Security Number, and current address will be released to the National Marrow Donor Program Registry to arrange for necessary insurance coverage. In regard to the details of your donorship, the National Registry will be furnished only your special donor identification number (not name or Social Security Number), HLA (human leukocyte antigen) type, ABO (red blood cell type), some other lab tests related to marrow donation, race, date of birth and sex. Only the DoD Marrow Donor Center will be able to match your name with your donor ID number.

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in disqualification as a potential donor.

I am in good general health. I am donating a blood sample to the Naval Medical Research Institute for HLA typing so that I may be included as a potential marrow donor through the National Marrow Donor Program for any patient in need of marrow transplant in an approved National Marrow Donor Program Transplant Center.

I agree to participate in the National Marrow Donor Program. I have had an opportunity to review an informational brochure concerning this program. I understand that I may discuss this information further with a representative of _____. My questions have been answered, and I have no further questions at this time.

I agree to the listing of my name, HLA typing, and other pertinent information deemed necessary in a Donor Center of the National Marrow Donor Program. I also agree to the release of specific information from this file to the National Marrow Donor Program. I understand that I may be contacted by this organization in the future. I understand that information released to and included in the National Marrow Donor Program will be listed in a coded fashion and all information will be maintained on a confidential basis so that my identity is protected. I further understand that my identity as a participant in this program will be known only to selected individuals in the program who will not further disclose that information without my consent.

I understand that my consent to participate in the National Marrow Donor Program may be the first step towards becoming a marrow donor. In order to participate in the Program, I consent to donate a small sample of blood for HLA testing. The blood sample is obtained by inserting a needle in my arm. I understand that this procedure is unlikely to cause complications, but there is a small chance of fainting, bleeding, or developing an infection or bruise at the site of the venipuncture.

If my HLA type matches that of any person in need of a marrow transplant, I will be offered a thorough educational program on marrow transplantation before being asked to make a decision about donating my marrow. In addition, a person (donor advocate) not employed by either the Donor Center or the Transplant Center will be available to assist me with any questions I may have. I understand that some forms of marrow transplantation are considered developmental or experimental with limited chances of success. I understand that by my participation in the Marrow Donor Program that I may be contacted by the DoD Marrow Donor Center to obtain informed consent for associated programs.

I understand that I have the right to withdraw from the Program at any time without prejudice to me. I reserve the right to make a final decision about marrow donation for a specific individual at a later date if such opportunity should arise.

SIGNATURE

DATE

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(Please print all information clearly.)

IN ADDITION, I WILL VOLUNTEER TO BE A PLATELET DONOR <i>(X one)</i>	YES
	NO

1. DONOR'S NAME <i>(Last)</i>	<i>(First)</i>	<i>(Middle Initial)</i>
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2. DATE OF BIRTH <i>(Month) (Day) (Year)</i>	3. AGE	4. SEX <i>(X one)</i> MALE FEMALE	5. SOCIAL SECURITY NUMBER
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6. DONOR'S ADDRESS a. NUMBER AND STREET

b. CITY	c.STATE	d. ZIP CODE
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7. PLACE OF WORK

8. WORK ADDRESS a. NUMBER AND STREET
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b. CITY	c.STATE	d. ZIP CODE
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9. TELEPHONE NUMBERS <i>(Include Area Code)</i> a. HOME	b. BUSINESS
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10. EMERGENCY CONTACTS <i>(Please list names of nearest relatives or friends who will always know how to reach you if we should be unable to.)</i>		
(1) a. NAME <i>(Last)</i>	<i>(First)</i>	b. RELATIONSHIP <i>(See codes below)</i>

c. ADDRESS <i>(Number and Street)</i>

<i>(City)</i>	<i>(State)</i>	<i>(Zip Code)</i>
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d. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>

(2) a. NAME <i>(Last)</i>	<i>(First)</i>	b. RELATIONSHIP <i>(See codes below)</i>
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c. ADDRESS <i>(Number and Street)</i>

<i>(City)</i>	<i>(State)</i>	<i>(Zip Code)</i>
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d. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>

RELATIONSHIP CODES: 01 - PARENT 02 - SIBLING 03 - SPOUSE 04 - CHILD 05 - OTHER RELATIVE 06 - FRIEND

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DONOR INFORMATION AND HEALTH SCREENING *(Continued)*

11. HEALTH RECORD *(X as applicable)* (NOTE: "Yes" answers do not automatically disqualify you. Please explain any "Yes" answers in detail below so that your response can be properly evaluated.)

YES	NO	
		a. Have you ever been refused as a blood donor or had problems donating blood?
		b. Have you ever had cancer, diabetes or other chronic illness?
		c. Have you ever had chest pain, shortness of breath, heart attack or other heart diseases?
		d. Have you ever had hepatitis, yellow jaundice, liver disease, or positive blood test for hepatitis?
		e. Have you ever tested positive to Human Immunodeficiency Virus (HIV) <i>(the virus of Acquired Immune Deficiency Syndrome (AIDS))</i> ?
		f. Have you received any blood transfusions or tattoos during the past six months?
		g. Have you ever had malaria, or taken any antimalarial drugs?
		h. In the past month, have you taken any prescription drugs?
		i. Have you ever taken Human Growth Hormone?
		j. Have you ever taken drugs by needle not prescribed by a physician?
		k. Are you in good general health?

i. Explanation of "Yes" responses *(Except line k)*

12. AFFILIATION *(X one)*

<input type="checkbox"/>	ARMY	<input type="checkbox"/>	MARINE CORPS	<input type="checkbox"/>	DOD CIVILIAN EMPLOYEE
<input type="checkbox"/>	NAVY	<input type="checkbox"/>	AIR FORCE	<input type="checkbox"/>	DEPENDENT ACTIVE DUTY

13. ETHNIC GROUP *(X as applicable)* *(Since certain HLA types may be more common in each ethnic group, this information may help in matching donors with patients.)*

AMERICAN CAUCASIAN - WESTERN EUROPEAN ANCESTRY <input type="checkbox"/> (1) Dutch <input type="checkbox"/> (5) Greek <input type="checkbox"/> (9) Scottish <input type="checkbox"/> (2) English <input type="checkbox"/> (6) Irish <input type="checkbox"/> (10) Spanish <input type="checkbox"/> (3) French <input type="checkbox"/> (7) Italian <input type="checkbox"/> (11) Swiss <input type="checkbox"/> (4) German <input type="checkbox"/> (8) Polish <input type="checkbox"/> (12) Other <i>(List)</i>			AMERICAN CAUCASIAN - EASTERN EUROPEAN ANCESTRY <input type="checkbox"/> (13) Bulgarian <input type="checkbox"/> (17) Russian <input type="checkbox"/> (14) Czech <input type="checkbox"/> (18) Yugoslavian <input type="checkbox"/> (15) Hungarian <input type="checkbox"/> (19) Other <i>(List)</i> <input type="checkbox"/> (16) Romanian		
ASIAN <input type="checkbox"/> (20) Chinese <input type="checkbox"/> (23) Japanese <input type="checkbox"/> (21) Filipino <input type="checkbox"/> (24) Southeast Asian <input type="checkbox"/> (22) Korean <input type="checkbox"/> (25) Other <i>(List)</i>			HISPANIC <input type="checkbox"/> (26) Central American <input type="checkbox"/> (29) South American <input type="checkbox"/> (27) Mexican <input type="checkbox"/> (30) Other <i>(List)</i> <input type="checkbox"/> (28) Puerto Rican		
MIDDLE EASTERN <input type="checkbox"/> (31) Arabic <input type="checkbox"/> (32) Jewish <input type="checkbox"/> (33) Other <i>(List)</i>		(34) NORTH AMERICAN AFRICAN <input type="checkbox"/> (35) CARIBBEAN <input type="checkbox"/> (36) AMERICAN INDIAN		(37) ASIAN INDIAN <input type="checkbox"/> (38) SCANDINAVIAN <input type="checkbox"/> (39) OTHER <i>(Specify up to four)</i>	

14. SIGNATURE _____ **15. DATE** *(MMDDYY)* _____

16. WITNESS
 a. NAME *(Last)* _____ *(First)* _____ *(Middle Initial)* _____

b. SIGNATURE _____