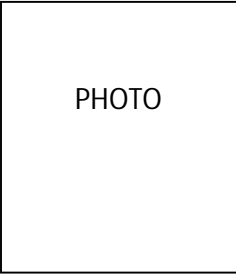




ICARE EYE BANK

(Regd. With Ministry of Health, Govt. of India)

ICARE EYE HOSPITAL



PLEDGE BY DONOR FOR REMOVAL OF EYES

I.....S/D/H/. ofage.....
yr, residing at

Hereby express my free consent for the removal of my eyes after my death from my body, by a registered medial practitioner of paramedic of a recognized eye bank/hospital for their use for therapeutic purposes, medical research and education. I have been explained and I understand all the aspects of such a donation.

Pledge Holder's Signature.....**Date**.....

Time.....**Phone (R)****Mob**.....

Off.....

Witness Name (preferably family member)**Witness Signature**.....

Relationship.....**R/O**.....

Phone.....

(Attach 2 Stamp – Size photographs)

Note:

- a) *The Eye Donation form is to be submitted in person/by courier to the following address
ICARE Eye Hospital - E-3A, Sector-26, Noida-201301, Ph. No.: 0120-2477600-02/9811992666.*
- b) *In case of death of pledge holder, inform immediately to nearest Eye Bank within 6 hours of death.*