



**SOUTH FLORIDA
BONE MARROW/STEMCELL
TRANSPLANT INSTITUTE**

EXPERIENCE * COMPASSION * RESULTS

WHITE BLOOD CELL DONOR Reply Form

NAME: (last, first) _____

PHONE NUMBER: _____

EMAIL: _____

DATE OF BIRTH: (mm / dd / yyyy) _____

MAILING ADDRESS: _____

By checking here you are authorizing that the South Florida Bone Marrow / Stem Cell Institute is using this information to determine your eligibility for the trial

INSTRUCTIONS:

Please fill out the above contact information completely. Also, please respond to questions 1 through 7 by checking the appropriate answers.

Send the completed form to:

**White Blood Cell Clinical Trial
Donor-participant Reply
South Florida Bone Marrow / Stem Cell
Transplant Institute
10301 Hagen Ranch Road
Suite 600
Boynton Beach, FL 33437**

Or you may fax this form to: (561) 752-5446

For additional information regarding this trial, please call the South Florida Bone Marrow / Stem Cell Transplant Institute research team at (561) 752-5522

1) What is your gender?

- MALE
 FEMALE

2) What is your self-described race?

- WHITE
 BLACK
 ASIAN
 OTHER

If *OTHER*, please specify below:

3) What is your Blood Type?

- | | | |
|-----|--------------------------|------------|
| A+ | <input type="checkbox"/> | A- |
| B+ | <input type="checkbox"/> | B- |
| AB+ | <input type="checkbox"/> | AB- |
| O+ | <input type="checkbox"/> | O- |
| | <input type="checkbox"/> | DON'T KNOW |

4) Have you donated blood or blood products in the past 12 months?

- YES
 NO

5) Have you ever been deferred from giving blood or blood products?

- YES
 NO

If *YES*, please specify the reason below:

reason: _____

6) Have you ever been diagnosed with cancer?

- YES
 NO

7) Has any member of your family been diagnosed with cancer?

Check all that apply:

- Primary relative (parent, brother or sister)
 Grandparent
 Aunts or Uncles
 Cousins
 Nieces or Nephews

If you know the type of cancer, write it below:

