BENIGN ESSENTIAL BLEPHAROSPASM RESEARCH FOUNDATION, INC.

Brain Donor Registration Form

Thank you for your commitment to become a brain donor. Please provide the following information on this form and return it to us. We will record your decision to be listed as a brain donor with the Harvard Brain Tissue Resource Center and submit your registration information to them. In addition, we will send you a wallet card along with contact information for the Harvard Brain Bank.

Donor Information

Date: _____

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____

E-mail: _____

Date of birth: _____

Neurologic diagnosis (if applicable): _____

Doctor treating diagnosis: _____

Donor Signature_____

Next-of-Kin Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

E-mail: _____

Relationship to Donor: _____

Please return this form to the address below. *If you have any questions, please contact us at 1-409-832-0788 or bebrf@blepharospasm.org*

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Email: bebrf@blepharospasm.org Website: www.blepharospasm.org