DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH
ORGAN/TISSUE BANK SCREENING FORM

Date: _____

1. Name: _____ Phone: _____
(Person completing form)

2. Title: _____ Institution: _____

3. Address: _____

4. Fax Number: _____ E-Mail Address: _____

5. Is your agency a current member of the American Association of Tissue Banks? __ Yes ___ No

6. With what activities is your agency involved in which relates to tissue harvesting and transplantation?

[ ] Procurement [ ] Furnishing [ ] Donating [ ] Processing [ ] Distributing [ ] None

[ ] Other (please specify): _____

7. Please indicate which organs and tissues are involved in the above activities and source of HIV testing of the tissue or donor, if any.

Organ/Tissue	Check if Tissue Applies to Question #6	HIV Test Performed on Donor or Tissue Prior to Transplantation	Source of HIV Testing*
		Yes Or No	
Kidneys			
Lung			
Pancreas			
Liver			
Eyes			
Skin			
Bone			
Heart Valves			
Sperm			
Blood			
Heart			
Other			
Other			
*Indicate agency or facility responsible for ensuring that HIV test is Performed.			

Please send completed form by e-mail to DHSS_DPH_tissuebank@delaware.gov or FAX to 302-739-2548.