



MAYO CLINIC

# *Blood Donor Program*

**Division of Transfusion Medicine**

**Mail to:** Mayo Clinic Blood Donor Program, Mayo Clinic, 200 1st Street SW, Rochester, MN 55902-9824  
507-284-4475 • donateblood@mayo.edu

Full Legal Name <i>(First, Middle, Last)</i>			
Address <i>(Include PO box, street address, apartment number, etc.)</i>			
City		State	ZIP Code
Mayo Clinic Number <i>(If known)</i>		Birth Date <i>(Month DD, YYYY)</i>	E-mail Address
Sex <i>(Select one)</i> <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <i>(Select one)</i> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Previous Names <i>(If applicable)</i>
Daytime Phone <i>(With area code)</i>		Evening Phone <i>(With area code)</i>	Cell Phone

Donation Date *(Month DD, YYYY)* \_\_\_\_\_ and Time *(hh:mm)* \_\_\_\_\_