LifeSaver Enrollment Form

Fields marked with an asterisk * are required.

* First Name	MI	* Last Name	SSN

City	State	Zip	* Birthdate (mm/dd/yyyy)

Home Phone	Family Physician

If you are protected by a Blood Bank of Delmarva membership, please specify membership name and number.

Membership Name

Membership Number

Have you ever given blood before? **Yes** **No**

I am available to donate:

[Anytime] [8:00am to 5:00pm] [5:00pm to 8:00pm]

I would be willing to donate:

[Once a year] [Twice a year] [Three or more times a year]

Preferred Donation Site:

[Christiana Center] [Wilmington Center] [Dover Center] [Salisbury Center] [Mobile Site (Please specify):

Blood Type:

Signature: ______________________________

This is **not** an application for membership in the Blood Bank.

Mail this form to:

Blood Bank of Delmarva
100 Hygeia Drive
Newark, DE 19713