

# National Kidney Registry

## Medical Certification Form

### Non-Directed Donor

*Fax your completed form & Basic Work Up Test Results to 800-401-8919 or mail to:  
PO Box 460, Babylon, NY 11702*

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### Medical Record Release Authorization and Agency Designation

(To be completed and signed by the donor)

I understand that I may be donating a kidney and as such may be undergoing surgery. I hereby provide The Kidney Registry with copies of my medical records, and I further authorize The Kidney Registry to disclose, disseminate, share, or otherwise utilize my medical information in order to find the best possible kidney match, by disclosing any necessary medical information to any necessary parties, for that sole purpose. I hereby designate The Kidney Registry as my non-exclusive agent for the sole purpose of coordinating, arranging, and handling the logistics of my surgery, and to request, receive, obtain and review, and be granted unconditional, full and unlimited access to any and all of my health, medical, and financial information. I consent to the disclosure of complete unredacted copies of any and all health, medical, and financial information to The Kidney Registry. I understand that The Kidney Registry will not sell, rent, or lease my personally identifiable information to any parties. I have read the Registration Agreement for The Kidney Registry, which I received with this document or as it appears on The Kidney Registry's web site, and will abide by it fully.

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DONOR SIGNATURE

PRINT NAME

TODAY'S DATE

DOB: \_\_\_\_\_

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### Donor Health Certification Form

(To be completed, signed, and dated by your physician)

I hereby certify that, in my professional opinion and based on the medical history and physical exam which I performed within the past twelve months, \_\_\_\_\_ is of healthy mind and body, and to my knowledge, has no physical or mental health reasons that should limit his/her ability to donate a kidney. **Please indicate the Donor's blood type \_\_\_\_\_.**

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PHYSICIAN SIGNATURE

PHYSICIAN PRINT NAME

TODAY'S DATE

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PHYSICIAN ADDRESS

PHYSICIAN PHONE #

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### Basic Tests Required

(To be completed with results faxed to National Kidney Registry)

1. CMP (Comprehensive Metabolic Panel)
2. U/A – Urinalysis
3. 24 Hour Urine for protein & Creatinine Clearance  
Protein-24 hour with Creatinine  
Clearance WEGFR

4. CBC (Complete Blood Count)
5. Hemoglobin A1C
6. Hepatitis Panel  
Hepatitis B Surface Antigen w/ confirmation  
Hepatitis B Surface Antibody QL  
Hepatitis B Core AB Total  
Hepatitis A AB,  
Hepatitis C Antibody