

**FORM 4**

**[Refer Rule 4 (1) (d)]**

I, Dr. .... possessing qualification of ..... registered as medical practitioner at Serial No ..... by the ..... Medical Council, certify that :-

(i) Shri.....s/o Shri.....aged ..... .. resident of.....and Smt .....D / o, w / o Shri ..... aged.....resident of.....Are related to each other as spouse according to the statement given by them and their statement has been confirmed by means of following evidence before effecting the organ removal from the body of the said Shri/ Smt. / Km .....(Applicable only in thecases where considered necessary).

OR

(ii) The clinical condition of Shri / Smt ..... mentioned above is such that recording of his /her statement is not practicable.

Place

Date

Signature of Registered Medical Practitioner

**FORM 5**

**[Refer rule 4(2) (a)]**

I, .....s / o, d / o, w / o Shri ..... aged ..... resident of ..... in the presence of mentioned below hereby unequivocally authorize the removal of my organ / organs, namely, ..... from my body after my death for therapeutic purposes.

Date

(Signature)

Signature of the Donor

1. Shri / Smt. / Km. .... s /o, w / o, d / o Shri ..... aged ..... resident of.....

(Signature)

2. Shri / Smt. / Km. ....s /o, w / o, d / o Shri..... aged ..... resident of ..... is a near relative to the donor as .....

Date.....