Georgia Eye Bank, Inc.
5605 Glenridge Drive/Atlanta, GA 30342
Phone (404)264-1900 Fax (404)264-9111

United States Surgeons

APPLICATION TO RECEIVE CORNEAL TISSUE FOR SURGICAL USE

PLEASE TYPE INFORMATION OR PRINT VERY CLEARLY

SURGEON NAME ____________________ DEGREE(S) ____________

Office Address ____
Street/PO Box City State Zip

Telephone ____________ FAX ____________ Contact Person ____________

State Medical License Number ______________________ (Please attach a copy)

Date of ABO Certification or Eligibility ____________ ABO# ____________

Training: (Please describe)

Residency: Institution/Dates ______________________________________

Training in Cornea and External Disease/Corneal Transplant Surgery

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Other Courses ____

(Attach a copy of your training documentation for our file.)

List all facilities where you perform surgery with donor Cornea tissue: Include address, Telephone/Fax number

1. ____

2. ____

3. ____

Please use additional pages if more than 3 facilities. Attach documentation of approval to perform surgical procedures at each facility.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE.

SURGEON SIGNATURE ______________________ DATE ____________

WITNESS SIGNATURE ______________________ DATE ____________

FOR GEB USE ONLY:

President/CEO Approval ______________________ Date ____________

Medical Director Approval ______________________ Date ____________