Georgia Eye Bank, Inc.
5605 Glenridge Drive NE Suite 250 Atlanta, GA 30342
Phone: (404) 264-1900 Fax: (404) 264-9111

APPLICATION TO RECEIVE CORNEAL TISSUE FOR SURGICAL USE

PLEASE TYPE INFORMATION OR PRINT VERY CLEARLY

Surgeon Name: _____

Office/Clinic Address:_____
Street City State Zip

Telephone: _____Fax: _____

Surgeon E-mail: _____ Surgeon's Mobile Phone: _____

Surgery Scheduler's Name/Phone/E-mail: _____

Assistant or Secretary Name/Phone/E-mail: _____

TRAINING

Medical School: _____ Residency: _____

Cornea/External Disease Fellowship: _____

Other fellowships / Ocular surgery training (if applicable): _____

Please include a copy of current CV, diplomas, certificates, etc.

Please list all facilities where you have been approved to perform ocular surgery using donor cornea tissue:

1. _____
2. _____
3. _____

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

Surgeon's Signature: _____ Date: _____

FOR GEB USE ONLY:

President & CEO Approval: _____ Date: _____

Medical Director Approval: _____ Date: _____