BUSINESS REPLY SERVICE
PERMIT NO. 01589

NATIONAL ORGAN TRANSPLANT UNIT
Outram Road
c/o Singapore General Hospital
Singapore 169608

Postage will be paid by addressee. For posting in Singapore only.

National Organ Transplant Unit

Please fold here

Note:

1. This organ donation pledge form only applies to individuals aged 18 years and above.
2. Please note that the organ(s) indicated in this organ donation pledge shall be recorded in the organ donation pledge registry and updated with any other organ pledge(s) made previously.
3. This form is invalid if it is not duly completed.
4. Please forward the completed form to the following address:
   National Organ Transplant Unit
   c/o Singapore General Hospital
   Outram Road
   Singapore 169608
5. If you do not receive an acknowledgment to your pledge for organ donation within 3 weeks, please contact the Officer-in-Charge at the above address or contact 63214390.

注：

1. 此遗体器官捐献认捐表仅适用于年满18岁或以上的人士。
2. 请注意，标明于上述遗体器官认捐表中的器官将收录于遗体器官捐献认捐记录中，同时与先前已签署的所有器官认捐表更新。
3. 若未填妥，此表格将视为无效。
4. 请将表格填妥后，寄送至以下地址：
   National Organ Transplant Unit
   c/o Singapore General Hospital
   Outram Road
   Singapore 169608
5. 若您在3个星期内未收到遗体器官捐献认捐表的确认函，请通过上述地址或电话（63214390）联系负责人员。

MEDICAL (THERAPY, EDUCATION AND RESEARCH) ACT 1972

ORGAN DONATION PLEDGE FORM UNDER SECTION 8

(This form may take you 5 minutes to fill in. Please complete all particulars in BLOCK LETTERS.)

医药（治疗、教育及研究）法令1972

在第8条文下的器官捐献认捐表

（此表格需约5分钟填妥，请使用英文大字母填写每一项。）

MINISTRY OF HEALTH
SINGAPORE

MEDICAL (THERAPY, EDUCATION AND RESEARCH) ACT 1972
ORGAN DONATION PLEDGE FORM UNDER SECTION 8

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For Official Use Only
仅供官方使用

FULL NAME **(as in identity document (ID))** 全名（如身份证所示）	
ID NO. 身份证号码	
CITIZENSHIP / RESIDENTIAL STATUS 公民权/居留身份	☐ Singapore Citizen 新加坡公民 ☐ Singapore Permanent Resident 新加坡永久居民 ☐ Others (please specify): 其他（请注明）：
DATE OF BIRTH (DDMMYYYY) 出生日期	**SEX** 性别 ☐ Male 男 ☐ Female 女
RACE 种族	☐ Chinese 华族 ☐ Malay 马来族 ☐ Indian 印度族 ☐ Others (please specify): 其他（请注明）：
HOME ADDRESS 住家地址	
POSTAL CODE 邮编	**CONTACT NO.** 联络号码

I hereby donate the following upon my death (please tick ' ✓ ' one box):
我在此认捐逝世时捐献下列项目（请勾选'✓'一项）：

☐ Whole body donation 大体捐献

☐ Any needed organs or parts 任何有需要的器官或部位

☐ Any organs or parts specified here: _____ 任何下列器官或部位：_____

My donation is for the purposes of (please tick ' ✓ ' all applicable boxes):
我的捐献为下列用途（请勾选'✓'所有适用项目）：

☐ Transplant and / or therapy 器官移植及/或治疗

☐ Medical / dental education, research, and / or advancement of medical / dental science 医药/牙科教育、研究以及/或医药/牙科科学发展

[OPTIONAL SECTION] A gift of all or any part of the body of a deceased person may be made to a specified donee* or without specifying a donee. This section may be left blank if you do not wish to specify a donee for the purpose(s) indicated above upon death.
[可选部分] 逝者可将大体或器官捐献予指定受益者*。若您无意为上述捐献用途指定受益者,可将此部分留白。

I wish to specify the following as donee, for the purpose(s) indicated above upon my death (optional):
我希望将上述捐献予以下指定的受益者（可选）：

Donation to specified individual for therapy or transplantation needed by him / her (if applicable): 捐献予需要治疗或器官移植的指定人（若适用）：	
FULL NAME (as in ID) 全名（如身份证所示）	
ID NO. 身份证号码	
Donation to specified approved hospital, or approved medical / dental school, college, or university (if applicable): 捐献予指定认证医院、认证医科/牙科院校、学院或大学（若适用）：	
NAME OF HOSPITAL OR MEDICAL / DENTAL SCHOOL, COLLEGE OR UNIVERSITY 医院或医药/牙科院校、学院或大学名称	
If the specified donee does not or is unable to accept, and / or does not need my body / organs upon my death (please tick ' ✓ ' one box): 若受益者不愿意或无法接受，且/或不需要我的大体或器官捐献（请勾选'✓'一项）： ☐ I agree to donate my body / organs to other donees for the purposes I have indicated above. 我同意将我的大体或器官捐献予其他受益者，以供上述用途。 ☐ I do not agree to donate my body / organs to other donees. 我不同意将我的大体或器官捐献予其他受益者。	
Remarks 备注	

*Donee refers to any specified individual, any approved hospital or approved medical / dental school, college or university.
*受益者指任何指定人，任何认证的医院或认证的医药/牙科院校、学院或大学。

Please note that under the Medical (Therapy, Education and Research) Act 1972:

1. A gift of a body or any part thereof may be revoked by the donor at any time.
2. If you have specified an individual as donee for the purposes of therapy or transplantation needed by him / her, kindly note that your organs will not be preserved for this purpose, if the specified donee does not require therapy or transplantation upon your death.
3. You are encouraged to discuss your decision to pledge the donation of your body / organs with your family members or next-of-kin so that they will be aware of your wishes. These members will be instrumental in ensuring that your wishes are carried out.
4. Upon your death, your health records (including electronic health records) will be accessed, to facilitate assessment of the suitability of your body / organs for donation.

请注意，在《医药（治疗、教育及研究）法 1972》下：

1. 捐献者可随时撤销其大体或部位的捐献。
2. 若您有指定的器官捐献受益者，但您指定的个人在您逝世时无需接受治疗或器官移植，您的器官将不会因为上述用途而被保存。
3. 若您有意登记为大体或器官捐献者，您受促事先向您的家人或子女讨论有关决定，以便他们可以确保顺利实现您的遗愿。
4. 在您逝世时，相关机构将查明您的健康医疗记录（包括电子医疗记录），以协助鉴定大体或器官适用于捐献用途。

SIGNATURE 签名	**DATE** (DDMMYYYY) 日期								

Please note that a person who is mentally disordered may not pledge the donation of his / her body / organs through submitting this form.
请注意，患有精神疾病者无法通过这项认捐表捐献其大体或器官。

WITNESS' PARTICULARS* 见证人资料*								
FULL NAME (as in ID) 全名（如身份证所示）								
ID NO. 身份证号码								
DATE OF BIRTH (DDMMYYYY) 出生日期								
CONTACT NO. 联络号码								
HOME ADDRESS 住家地址								
POSTAL CODE 邮编								
RELATIONSHIP 关系								
SIGNATURE 签名								
DATE (DDMMYYYY) 日期								

In the event of my death, please contact:
若我不幸逝世，请联络：

FULL NAME (as in ID) 全名 （如身份证所示）	**CONTACT NO.** 联络号码							
HOME ADDRESS 住家地址								
POSTAL CODE 邮编								

**Witness must be 21 years of age or older.*
**见证人必须年满21岁。*