National Kidney Foundation® of Wisconsin

MEDICAL IDENTIFICATION JEWELRY
Request Form

First Name MI Last Name

Street Address

City State ZIP County

Employer ☐ No employer

__/__/__ *(Please Print)*
Date of Birth (mm/dd/yy)

☐ Home
☐ Cell
☐ Work
( ) -
Preferred Phone

Email ☐ No email

The National Kidney Foundation of Wisconsin will not sell or share your information.

I am a:
☐ dialysis patient
☐ transplant recipient
☐ living donor

☐ person living with diabetes Insulin? ○Yes ○No
Transplant date: __/__/__
Date of Transplant (mm/dd/yy)

☐ person with high blood pressure ☐ Other_____

Transplant Center

PRINT all information to be engraved.
Include **full name, date of birth, emergency contact phone (ICE), any life-threatening allergies**.

Front

Line 1																
Line 2																
Line 3																
Line 4																
Line 5																

Back *Information outside the spaces will not be engraved.*

Line 1																
Line 2																
Line 3																
Line 4																
Line 5																

SAMPLE

Front

Line 1	J	O	H	N		D	O	E								
Line 2	D	O	B		5	/	5	/	5	5						
Line 3	I	C	E		7	1	5	-	1	2	3	-	4	5	6	7
Line 4																
Line 5																

Back

Line 1	H	E	M	O	D	I	A	L	Y	S	I	S				
Line 2	A	L	L	E	R	G	Y		P	C	N					
Line 3	L	F	T		F	I	S	T	U	L	A					
Line 4																
Line 5																

Patient Acknowledgement

I request the National Kidney Foundation of Wisconsin (NKFW) to provide the medical ID jewelry as described on this form. I understand that NKFW may contact me about programs, events, or with information that may be of interest to me.

Signature

Date

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National Kidney Foundation® of Wisconsin

MEDICAL IDENTIFICATION JEWELRY
Request Form

Patient Name

Jewelry is 100% jewelry quality stainless steel. Select one:

☐ Bracelet	☐ Neck Chain
Regular weight chain, 9" long	27" continuous loop chain.

Please allow up to 6 weeks for processing and delivery.

HEALTHCARE PROVIDER INFORMATION

Medical Professional Name *(Please Print)*

Title

Direct Line/Extension *(Required)*

Mailing Address *(Required)*

Email *(Required)*

City State ZIP

Healthcare Provider Acknowledgement

I assisted _____ in completing this medical ID jewelry request form.

Signature

Date

Check One: ☐ First time/change order (New patients or change in medical condition)
COST: Free *Contributions to help with shipping and handling are appreciated.*

☐ Replacement order
COST: $20.00

☐ Amount enclosed (paying with cash, check, or money order): $_____

☐ Paying with credit card and will call to provide credit card information.

Mail: National Kidney Foundation of Wisconsin
10909 W Greenfield Ave, Suite 201
West Allis, WI 53214-2379

Fax: 414-930-0337
Email: NKFW@KidneyWI.org
Information/credit card payment: 414-897-8669

Don't miss a thing! Provide your email address to stay connected: _____

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