National Kidney Foundation® of Wisconsin

2017
MEDICAL IDENTIFICATION JEWELRY
Order Form

(Please Print)

First Name MI Last Name

Date of Birth (mm/dd/yy)

Street Address

☐ Home
☐ Cell
☐ Work

( ) -

Preferred Phone

City State ZIP County

Employer ☐ No employer

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? OYes ONo
Transplant date: / /
Date of Transplant (mm/dd/yy)

☐ person with high blood pressure ☐ Other_____

Transplant Center

PRINT all information including:
Full name, date of birth, any life-threatening allergies and **emergency contact phone (ICE).**

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

By requesting this medical DI jewelry, I give permission to the National Kidney Foundation of Wisconsin to send me information about its programs and events.

Signature

Date

National Kidney Foundation® of Wisconsin

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MEDICAL IDENTIFICATION JEWELRY
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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)*

Position/Credentials

Direct Line/Extension *(Required)*

Mailing Address *(Required)*

Email *(Required)*

City State ZIP

Check One: ☐ First time order
COST: Suggested contribution of $10 to help with shipping and handling.

☐ Replacement order
COST: $20.00

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

Fax: 414-930-0337

Contributions/Information: 414-897-8669

HEALTH PROGRAMS & EVENTS

facebook.com/nkfwi