

F O R M - 9

I, Shri/Smt \_\_\_\_\_ s/o, w/o Shri \_\_\_\_\_  
\_\_\_\_\_ resident of \_\_\_\_\_  
\_\_\_\_\_

hereby authorize removal of the organ/organs, namely, \_\_\_\_\_  
\_\_\_\_\_

for therapeutic purpose from the dead body of my son/daughter Shri/Km \_\_\_\_\_  
\_\_\_\_\_ aged \_\_\_\_\_ whose brain-stem  
death has been duly certified in accordance with the law.

Signature \_\_\_\_\_

Name \_\_\_\_\_

Place \_\_\_\_\_

Date \_\_\_\_\_