AABB United States Donor Hemovigilance Program

Enrollment Form

Please complete the information below to provide the necessary information to participate in the AABB United States Donor Hemovigilance Program. Your participation is critical for the success of this initiative. By collaborating with your peers in the blood collection community, we can work to ensure that donor health and safety are enhanced.

Please provide the information requested below:

Date:  ___________________________

Contact Name: ___________________________________________  Title: _________________________________

Organization: ___________________________________________________________________________________

Collection Center Name:  __________________________________________________________________________

Address: ________________________________________________________________________________________

City, State, Zip: ___________________________________________________________________________________

Email: _______________________________________________  Phone: ___________________________________

Total Units Red Blood Cells Collected Annually: ________________________________________________________

Donor Center Computer System and Software version:  _________________________________________________

☐ Please check here if AABB may include your organization’s name in a list of facilities that have agreed to participate in AABB’s Hemovigilance activities.

Please complete, sign and return this form via email to hemovigilance@aabb.org, mail or fax to:

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