NAME & ADDRESS OF BLOOD BANK

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Licence No.:-__________________________

BLOOD DONOR COUNSELING REGISTER
(CONFIDENTIAL)
(BD-9)

Unit No.	Collection date	TTI REPORT	Donor's Name	Age/ Sex	Address with e-mail ID	Contact Phone No.	Contacted on	Counseling date & details	Action taken	Remarks	Sign Of Counselor	Signature of Donor

Signature of Quality Manager/Supervisor:__________________________

BD-9