



COVID-19 Convalescent Plasma Donor Request Form

Please fill out the form below and we will contact you as soon as possible.			
First Name:	Middle Name:	Last Name:	
Other Names Used (if any):		Home Phone:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Work Phone:	
Mailing Address:			
City:	State:	Zip:	
Email:			
<p>Was your COVID-19 diagnosis confirmed by a lab test?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you currently have symptoms (fever, cough, shortness of breath, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the date of your last symptoms?</p> <p>While receiving treatment for COVID-19, were you transfused with convalescent plasma?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Have you received a vaccine for COVID-19?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Please attach your official laboratory results report (Note: report must include your name and date of birth).			
<p>Please submit your completed form (and attached results report) to the Blood Bank of Alaska by any of the following methods.</p> <ul style="list-style-type: none"> • Email: QualityAssuranceDepartment@bbak.org • Fax: (907) 563-1371 • Drop Off: Any blood bank location 			
Blood Bank of Alaska Staff Only			
CCP Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Donor Number: Eligibility Date:	<input type="checkbox"/> LifeTrak Updated <input type="checkbox"/> HemaConnect Updated	Completed By/Date:
<input type="checkbox"/> RECR Mgmt Notified		Final Review By/Date:	
Comments:			