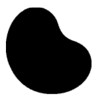

National Kidney Foundation® of Michigan

Medical Emergency ID Tag Program

Patient Name: ______________________________

Address: ____________________ City: ____________ State: ________ Zip: ________

Phone Number: (_____) ____________ County: ____________ Email: ____________________

Please Select:

❑ Bracelet $6.00
❑ Necklace $6.00

Bracelet is 8” long. Please provide additional length required ________

Ship to:

❑ Patient
❑ Facility

Social Worker Name: ______________________

Unit Name: ______________________

Unit Address: ______________________

City: ____________ State: ________ Zip: ______

Phone Number: (_____) ______________________

One letter per box

Patient’s Name																		
Modality*																		
Misc. Information**																		
24 Hour Emergency Contact (1st Name & Contact Number for Friend/Family Member)																		
Doctor’s Last Name & Contact Number																		

* Hemodialysis, Peritoneal Dialysis, Transplant
** Drugs, Dyes, Diabetes, Heart Disease, Allergies, etc.

Do you receive Medicaid? (e.g. mihealth card, Healthy Michigan Plan, MIChild, etc.)

❑ Yes
❑ No

Return completed form with payment to the:
National Kidney Foundation of Michigan
1169 Oak Valley Drive | Ann Arbor MI 48108
PHONE 734.222.9800 | FAX 833.292.6778

www.nkfm.org

Updated: 1/9/2020

OFFICE USE ONLY

Check Number ____________ Cash ____________ Money Order ____________

Date on Check ____________ Date Received ____________ Date Entered ____________

Client # ____________ Date Sent to Engraver ____________