DEPARTMENT OF ANATOMY AND CELL BIOLOGY

Name of Donor (Please type or print)

2300 I STREET, N.W. • WASHINGTON, DC 20037
(202) 994-3511 • FAX (202) 994-8885

This copy for ☐ Medical Center

☐ Donor

INSTRUMENT OF ANATOMICAL GIFT

Declaration of Intent

I, ______________________________________, being of sound mind and capable of making a decision without coercion or suggestion, do hereby request that upon my death, prior to either an autopsy or embalmment, my remains shall be donated to THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER. My body is bequeathed for such legitimate teaching, research, or other purposes as the above institution may deem advisable subject to the needs of the institution at that time. Should my death occur at a distance outside an approximate radius of 50 miles from The George Washington University Medical Center, my body shall go to the nearest medical center.

______________________________________ (Signature)

Address: ______________________________ (Street)

Date: ______________________________

______________________________ (City) (State) (Zip)

Phone Number: (_______) ______________

Witness Attestation

Name: ______________________________

Address: ______________________________ (Street)

Date: ______________________________

Phone Number: (_______) ______________

______________________________ (City) (State) (Zip)

Name: ______________________________

Address: ______________________________ (Street)

Date: ______________________________

Phone Number: (_______) ______________

______________________________ (City) (State) (Zip)

Declaration of Consent

I, ________________________, ________________________, of ________________________,
(Next of Kin) (Relationship) (Donor)

do hereby give my consent for the disposition of his/her body to THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER.

________________________________ **Address:** ________________________
(Signature) (Street)

Date: ________________________________ ________________________________
(City) (State) (Zip)

Phone Number: (_______) ______________

WHY BEQUEATHALS ARE NEEDED: Only through the bequeathal of bodies to medical centers can future physicians receive adequate training. There is no maximum age limitation for anatomical gifts.

SUGGESTIONS TO THE DONOR:

1. **Clear with your family.** It is important that your plans be understood and accepted by your family both in deference to their feelings and to assure the carrying out of your wishes.
2. **What to do with this form upon its completion.** One copy goes to this medical center; one you keep for your own records. You may also wish a copy to be given to your attorney, next of kin, physician, memorial society or funeral director.
3. **Alternative arrangements.** Alternative arrangements for the disposition of the body should be made in the event that an autopsy is performed, the body is severely damaged due to an accident, a diagnosis of AIDS, recent extensive surgery, a communicable disease or outside the 50 mile radius.
4. **Donor card.** The medical center, upon receipt of your completed form, will send you a donor card. This card, properly executed, is a legal document which should be carried in your purse or wallet.

PROCEDURE AT TIME OF DEATH: The medical center should be notified of the death by telephone: the Department of Anatomy & Cell Biology (202-994-3511) weekdays (8:30 a.m.-5:00 p.m.). A voice mail message informs callers of procedures during evenings, weekends, and holidays. The Medical Center will arrange at its expense for transportation of the remains within a 50 mile radius.

ULTIMATE DISPOSAL OF THE REMAINS: The studies will be done over an eighteen to twenty-four month period. Upon completion of our studies, the Medical Center will cremate the body. The cremains will either be returned to the family at their request or interred by the Medical Center in a local cemetery. Please check your preference below:

☐ **Return Cremains** ☐ **DO NOT Return Cremains**

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
VITAL STATISTICS

(This information will remain Confidential)

NAME ____
(Last) (First) (Middle)

SEX Male ☐ Female ☐

DATE OF BIRTH
(Month) (Day) (Year)

RACE ______________________________

CITIZEN OF WHAT COUNTRY ______________

PLACE OF BIRTH ________________
(State)

SOCIAL SECURITY NUMBER ____________________

MARITAL STATUS Married ☐ Never Married ☐ Widowed ☐ Divorced ☐

USUAL OCCUPATION (Give type of work done during most of working life even if retired/kind of business or industry).

EDUCATION (specify any highest grade completed)
Elementary/Secondary (1-12)

COLLEGE (1-4 or 5+)

USUAL RESIDENCE ____
(Street address, if rural, give location)

FATHER'S NAME ____
(First) (Middle) (Last)

MOTHER'S NAME ____
(First) (Middle) (Maiden Name)

HAVE YOU EVER SERVED IN THE ARMED FORCES? Yes ☐ No ☐ Veteran ________________
If yes give year or dates ____

NAME AND ADDRESS OF SPOUSE
OR NEAREST RELATIVE ____
(First) (Middle) (Last)

____
(Street Address) (City or Town) (State) (Zip Code)

Telephone: (__________) ________________________
area code

Please answer the required information above as completely as possible.
The vital statistics are necessary for filing a certificate of death, as required by law.

NOTE: COMPLETE THIS INFORMATION FOR OFFICE COPY ONLY.