Northeast Ohio MEDICAL UNIVERSITY

Department of Anatomy & Neurobiology
Body Donation Program

4209 St. Rt. 44, PO Box 95
Rootstown, OH 44272
P: 330.325.6317
F: 330.325.5916 www.neomed.edu

Anatomical Bequeathal Form

(Please retain a copy of this form for your records)

Instructions: (Please print or type) Complete the entire form, including appropriate signatures, and return the original form to the address listed above.

Name _____ SSN _____
(Last) (First) (Middle)

Street _____ City _____ State _____ Zip _____

Inside City Limits? Yes ❑ No ❑ County _____

Date of Birth (MM/DD/YYYY) _____ Place of Birth (City/State) _____

Female ❑ Male ❑

Home Phone ( ) _____ Cell Phone ( ) _____

Email Address: _____

Marital Status ❑ Never Married ❑ Married ❑ Widowed ❑ Divorced

If Married Male, Spouse Maiden Name _____

If Married Female, Spouse Name _____

Is your spouse or a relative registered with the Body Donation Program at Northeast Ohio Medical University?
If yes, please give name(s)

_____

Occupation (before retirement) _____

Kind of Business _____

Race (American Indian, Black, White, etc.) _____

Hispanic Origin? (If yes, - Cuban, Puerto Rican, etc.) _____

Any Amputations? Yes ❑ No ❑ If Yes, Specify _____

Current Height _____ Current Weight _____

Any Major Surgeries? (Such as heart, hysterectomy, gall bladder, etc.)_____

Education (Highest grade completed) _____

Father's Full Name _____

Mother's Full Name (Maiden) _____

Next of Kin (order of legal descent: spouse, children, parents, siblings)

Name _____ Relationship _____
(Last) (First) (Middle)

Street _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

U.S. Armed Forces Veteran Yes ❑ No ❑

If Yes, please send a copy of Honorable Discharge papers (DD214 Form) and complete section below:

_____ _____
Date Entered Service Date Separated from Service

_____ _____
Place Entered Service Place Separated from Service

_____ / _____
Service Number Branch of Service Grade, Rank or Rating

Please initial each blank line at the X to indicate agreement to that condition.

1. X____ I understand that the decision to accept my body will not be made until the event of my death.
2. X____ The acceptance of these forms does not constitute a contract with the Body Donor Program (the "Program") at the Northeast Ohio Medical University (NEOMED).
3. X____ I understand the following restrictions may prevent the acceptance into the Program:
    A. A body that has been embalmed elsewhere.
    B. A body that has undergone an autopsy.
    C. A body of a person who has excessive edema.
    D. A body of a person who dies during major surgery or shortly thereafter.
    E. A body if any organs or tissues have been donated at the time of death.
    F. A body that demonstrates severe permanent contractures of the extremities.
    G. A body of a person who has died of an accidental or suicidal death.
    H. An obese body (calculated at BMI of 30% of deceased height and weight).
    I. A body of a person who has died of or with a contagious or infectious disease (i.e., but not limited to, septicemia, hepatitis, MRSA, AIDS, bacterial pneumonia, CJD, etc.).
    J. The body of a person who has limbs amputated.
    K. The body of a person who has died outside of a 75-mile radius of NEOMED unless prior arrangements have been made.
    L. The body of a person who has died outside of the state of Ohio.
    M. The body of a person who died at a time when NEOMED is not open (e.g., a national holiday or weather-related closing).
    N. I understand that it is prudent that I have alternative arrangements for the disposition of my body if my body is refused for donation into the Program for any of the reasons listed above.
4. X____ I understand that the Program will not release a report to family members pertaining to our educational or research activities.
5. X____ I understand that it is my responsibility to contact the Program with any information to be updated (change of address, next of kin designation, marital status, etc.) for my donation to remain current.
6. X____ I understand that I may withdraw from the Program at any time by sending a signed and dated letter to the Program. A letter confirming my withdrawal from the Program will be sent to me in return.
7. X____ I understand that I am responsible for sharing my decision to donate and all policies of the Program with my family.

8. X____ In the event that my donation is accepted at the time of death, I understand that my decision as to the final disposition of my cremated remains is irrevocable.

9. X____ I understand that the exact use of my anatomical gift will be left to the discretion of the Program Director.
10. X____ I understand my body may be used by the Program or by other health centers, or other educational or research institutions approved by the Program.
11. X____ I understand that my body will be cremated at the conclusion of the educational or research activities conducted under the Program.

I request the following final disposition of the cremated remains (please initial ONE below)

_____ That they be kept by the NEOMED Department of Anatomy and Neurobiology and handled as part of the common burial. Cremains that are not returned to donor's family will be buried in a separate container in a common burial site. The NEOMED Department of Anatomy and Neurobiology will be responsible for the cost of interment.

_____ That they be returned to the party indicated below. I understand, by agreeing to the terms of the Program, that some of my cremains may not be returned. The Program reserves the right to retain part of the donation for future educational and/or research purposes and these will not be returned.

Name Relationship

Street City State Zip

Home Phone ( ) Cell Phone ( ) Email

I have read and understand and I agree to the conditions for donation of my body to the Body Donor Program. I further understand and agree that acceptance of my body into the Program will be determined at the time of my death and that the Program reserves the right to refuse any donation. By signing below I also give authorization to release my medical records to the NEOMED Department of Anatomy and Neurobiology.

Signature of Donor/Guardian/POA* Date

Signature of Witness Date

Signature of Witness Date

* If a Power of Attorney (POA) is signing for a Donor, please include a copy of the applicable POA form.

It is not necessary to have this form notarized, but it must be signed and witnessed.

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Cremation Authorization Form

NAME OF DONOR _____
Please Print

Please initial EACH blank to indicate you have read and agree with the statement.

1. _____ ❑ I have ❑ do not have knowledge of the presence of a pacemaker, or any other device or implant that may pose a hazard to the health or safety of crematory personnel. Please describe the device if applicable:_____
2. _____ I understand the crematory will cremate the chamber in which the remains are delivered to the crematory.
3. _____ I understand that the remains will be cremated separate from any other donor.
4. _____ I understand that no one other than crematory personnel may be present in the holding room or cremation room prior to or during cremation, or during the removal of the cremains from the chamber.
5. _____ I understand that after cremation, the cremains will be processed according to the practice of the crematory. Such processing includes removal of foreign matter (especially metal from clothing, from dental work, or from containers) which remains after cremation. Some small pieces, however, may escape human detection and be included in the cremated remains.
6. _____ I understand that although the crematory will take reasonable efforts to remove all of the cremains from the cremation chamber, it is impossible to guarantee absolute removal of all cremains from the chamber.
7. _____ The crematory will perform the cremation of the donor at a time and date as its work schedule permits and without notification to the agent.
8. _____ The Authorizing Agent acknowledges that NEOMED Department of Anatomy and Neurobiology and the crematory facility are relying upon the information and statements being provided by the person(s) in this authorization. I certify that all of the information and statements contained in this authorization form are accurate and that I have not omitted any material facts that may be relevant to the Program.
9. _____ I agree to indemnify and hold harmless NEOMED Department of Anatomy and Neurobiology and the crematory facility, their officers, directors, employees and agents from any and all claims, demands, actions, causes of action or suits of any kind or nature whatsoever, including, but not limited to, any legal fees arising out of or resulting from NEOMED Department of Anatomy and Neurobiology's and the crematory facility's reliance on or performance consistent with the directions, statements, representations and agreements contained in this authorization, to the full extent of any, and all applicable, statutory immunity provided in Rev. Code 4717.30.

Signature of Donor/Guardian/POA*_____Date_____

Signature of witness_____Date_____

Signature of witness_____Date_____

* If a Power of Attorney (POA) is signing for a Donor, please include a copy of the applicable POA form.