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)

*If any of your contact information should change, please e-mail changes to **bodydonation@neomed.edu**

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

Name (Last) (First) (Middle) SSN

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, Spouse Name

If applicable, Spouse Maiden Name

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.)

Highest Level of Education (Check ONE of the Following)

- ❑ 8th grade or less
- ❑ 9th -12th grade, no diploma
- ❑ High school diploma or GED
- ❑ Some College, No degree
- ❑ Associates Degree (e.g., AA, AS)
- ❑ Bachelor's degree (e.g, BA, BS)
- ❑ Master's degree (e.g., MA, MS)
- ❑ Doctorate or Professional Degree

Father's Full Name

Mother's Full Name (Maiden)

Name _____ **Date of Birth**_____

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 Ratin

Is your spouse or a relative registered with the Body Donation Program at Northeast Ohio Medical University?

If yes, please give name(s)

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

Name Relationship

(Last) (First) (Middle)

Street City State Zip

Phone E-mail

Secondary Contact:

Name Relationship

(Last) (First) (Middle)

Street City State Zip

Phone E-mail

Name _____ Date of Birth_____

Please initial each blank line to indicate agreement to that condition.

1. _____I understand that the decision to accept my body will not be made until the event of my death.
2. _____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. _____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. _____I understand that the Program will not release a report to family members pertaining to our educational or research activities.
5. _____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. _____I understand that I may withdraw from the Program at any time by sending a signed and dated letter to the Program.
7. _____I understand that I am responsible for sharing my decision to donate and all policies of the Program with my family.
8. _____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. _____I understand that the exact use of my anatomical gift will be left to the discretion of the Program Director.
10. _____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. _____I understand that my body will be cremated at the conclusion of the educational or research activities conducted under the Program.

Name _____ **Date of Birth**_____

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. Please list two names in order of priority**. In the event the primary name is not available remains will be given to the second name listed. 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.

Primary Name _____ Relationship _____

Street _____ City _____ State _____ Zip _____

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

If my primary representative is disqualified from serving as my representative, I hereby appoint the following person to serve as my successor representative:

Secondary 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. Being of sound mind, I willfully and voluntarily appoint my representative, named above, to have the right of disposition for my body effective upon my death. All decisions made by my representative with respect to the right of disposition shall be binding and if any dispute arises with respect to my remains, I understand NEOMED will comply with the terms of the executed forms. 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

_____

I attest that the Donor signing this assignment was of sound mind and not under or subject to duress, fraud, or undue influence.

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 (Please print)

NAME OF DONOR _____

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

1. _____ ❑ I have ❑ do not have 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 NEOMED or anyone listed on these forms.
8. _____ The undersigned party 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_____

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

Signature of witness_____Date_____

Signature of NEOMED Funeral Director _____ Date_____

Date of Birth _____ Date of Death_____

(For NEOMED use only) (For NEOMED use only)