

**UNIVERSITY OF ROCHESTER MEDICAL CENTER ANATOMICAL GIFT PROGRAM**  
**“DECLARATION OF DONATION”**

Being of sound mind and body and being 18 years of age or older, I direct that immediately after my death, my body be made available to the nearest medical school for education, and/or research, as authorized by Section 4301 of the New York State Public Health Law.

Since the intact body is of greatest value for medical teaching and/or research, no autopsy should be performed on my body. However, the receiving medical school may embalm and/or perform an autopsy for the purposes of education and/or research.

Should my death occur in Monroe County (New York): I request that the University of Rochester School of Medicine and Dentistry be designated to carry out my direction. In such case, notice should be given promptly, no later than 24 hours following my death, to the Admitting Office of Strong Memorial Hospital, 601 Elmwood Avenue, Rochester, New York, 14642, (585) 275-2270, or the Anatomical Gift Program at the same address (585) 275-2592.

The recipient of my body shall have the right to transfer my body to any other institution legally authorized to receive anatomical gifts in the event it is determined that the purpose of medical education, and/or research would be better served by such transfer. I authorize the receiving institution to perform the embalming and/or cremate my body following its use, (most commonly one to two years) after death.

***It is our policy to accept and use as many donor bodies as possible, but circumstances sometimes arise which make it inadvisable for us to accept a donor. You should make alternative arrangements for the disposition of your body in case it is unacceptable to the Medical School***

A. THE UNIVERSITY OF ROCHESTER CANNOT PAY TRANSPORTATION COSTS IF DEATH OCCURS OUTSIDE MONROE COUNTY. SHOULD MY DEATH OCCUR OUTSIDE MONROE COUNTY (NEW YORK), I DIRECT THE FOLLOWING:  
(Check ONE of the following two statements)

1. \_\_\_\_\_ My body be made available to the nearest medical school, and my executor be authorized to pay from my estate any costs for transportation.
2. \_\_\_\_\_ My executor be authorized to pay from my estate the cost of transportation of my body to the University of Rochester School of Medicine and Dentistry.

B. IF MADE AVAILABLE TO THE UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY, I THE UNDERSIGNED HEREBY GIVE THE UNIVERSITY OF ROCHESTER CREMATORIUM FULL AND COMPLETE AUTHORITY TO CREMATE MY REMAINS AND RELEASE THE UNIVERSITY OF ROCHESTER CREMATORIUM FROM ANY AND ALL LIABILITY ON ACCOUNT OF SAID AUTHORIZATION AND CREMATION. MY REMAINS SHOULD BE DISPOSED OF IN ACCORDANCE WITH THE STATEMENT CHECKED BELOW (Check ONE of the following two statements):

1. \_\_\_\_\_ Be cremated following the use of my body (most commonly 1 to 2 years later), and inter my cremated remains at the burial site of the University of Rochester.
2. \_\_\_\_\_ Be cremated following the use of my body (most commonly 1 to 2 years later) without cost to my estate, and the ashes be made available to my heirs who will assume the cost of burial. My cremated remains should be made available to the person listed below: (Please print):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_

Signed by the Donor in ***the presence of the following two people***, who sign as witnesses (when possible, witnesses should be your legal next of kin, ie: spouse, children, sibling, executor named in your will):

[1] **Witness: please print clearly all information, then sign and date where designated:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

[2] **Witness: please print clearly all information, then sign and date where designated:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Donor Signature:** \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

**THE FOLLOWING STATISTICAL INFORMATION CONCERNING DONOR (YOURSELF) IS REQUIRED  
FOR THE PROPER COMPLETION OF THE CERTIFICATE OF DEATH. PLEASE PRINT OR TYPE.**

One Original copy of this form properly completed and signed should be sent to the University of Rochester Medical School, Anatomical Gift Program, 601 Elmwood Ave, Box 709, Rochester, NY 14642. Also to this address, you must send in writing any necessary changes in the information supplied on this form. Please advise any institution, hospital, or nursing home, etc. of your donation. **TYPE OR PRINT CLEARLY ALL INFORMATION.**

1. Name: (first) _____ (middle) _____ (last) _____			2. Sex: [ ] Male [ ] Female
3. Age: _____	4. Birth Date: _____	5. Soc. Sec. #: _____	16. Education: ( check highest level or degree completed) <input type="checkbox"/> 0-8 <input type="checkbox"/> College credit, but no degree <input type="checkbox"/> Master's degree <input type="checkbox"/> 9-12, no diploma <input type="checkbox"/> Associate's degree <input type="checkbox"/> Doctorate or Professional degree <input type="checkbox"/> High School Grad / GED <input type="checkbox"/> Bachelor's degree
6. Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian (specify) _____ <input type="checkbox"/> Amer. Indian or Alaska Native (specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other (specify) _____			
7. Of Spanish / Hispanic / Latino Origin: [ ] Yes [ ] No (If yes, check below appropriately) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Central or South Amer. <input type="checkbox"/> Other (specify) _____			17. Your legal address: House #/Street/Apt #: _____ City / State / Zip: _____ County: _____
8. Veteran of U.S. Armed Forces:    If yes, below, specify war or dates of service: <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. City and State of Birth: (If not born in the U.S.A, give town and country.)			18. Locality: ( <b>Check one and specify</b> ) <input type="checkbox"/> City of: _____ <input type="checkbox"/> Town of: _____ <input type="checkbox"/> Village of: _____
10. Citizen of what Country:			
11. Marital Status: [ ] Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			19. Name of Father: ( <b>First, Middle, Last name</b> )
12. Spouse's Name: (If wife, please give her maiden name)			
13. Your Chief occupation: ( <b>even if retired</b> )			20. Name of Mother: ( <b>First, Middle, Maiden Last name</b> )
14. Type of business or industry:			
15. Name and address of chief employer: ( <b>If retired, give last employer</b> )			
			21. Name of immediate next of kin: _____ Address: _____ City/State/Zip: _____ Phone #: (    ) _____ <b>Relationship:</b> _____

We may obtain any additional information needed concerning yourself from: (fill in each section with all requested information – if you have no attorney, just place “N/A” in that area)

Attorney:	_____	_____	_____
	Name	Complete Address	Phone
Physician:	_____	_____	_____
	Name	Complete Address	Phone
Additional Relative: (other than # 21)	_____	_____	_____
	<b>Name and Relationship</b>	Complete Address	Phone
3 <sup>rd</sup> Relative / or Close Family Friend	_____	_____	_____
	<b>Name and Relationship</b>	Complete Address	Phone