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

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. ***<u>TYPE OR PRINT CLEARLY ALL INFORMATION</u>.***

1. **Name: (first) (middle) (last)** | 2. Sex at birth: [ ] Male [ ] Female

3.Age: | 4. Birth Date: | 5. Soc. Sec. #:

6.Race (check all that apply): [ ] White [ ] Black or African American
[ ] Asian (specify) _____
[ ] Amer. Indian or Alaska Native (specify) _____ [ ] Native Hawaiian
[ ] Other (specify) _____

7. Of Spanish / Hispanic / Latino Origin: [ ] Yes [ ] No (If yes, check below appropriately)
[ ] Mexican [ ] Mexican American [ ] Chicano [ ] Cuban [ ] Central or South Amer.
[ ] Other (specify)_____

8. Veteran of U.S. Armed Forces: If yes, below, specify war or dates of service:
[ ] Yes [ ] No _____

9. City and State of Birth: (If not born in the U.S.A, give town and country.)

10. Citizen of what Country:

11. Marital Status: [ ] Never Married [ ] Married
[ ] Separated [ ] Widowed [ ] Divorced

12. Spouse's Name: (If wife, please include maiden name)

13. Your main occupation in life: ***(Do not enter retired)***

14. Type of business or industry:

15. Employer name and location (city/state) from Item #13.

16. Education: ( check highest level or degree completed)
[ ] 0–8 [ ] College credit, but no degree [ ] Master's degree
[ ] 9 – 12, no diploma [ ] Associate's degree [ ] Doctorate or
[ ] High School Grad / GED [ ] Bachelor's degree Professional degree

17. Your legal address:
House #/Street/Apt #: _____
City / State / Zip: _____
County: _____

18. Locality: (***Check one and specify)***
[ ] City of: _____
[ ] Town of: _____
[ ] Village of: _____

19. Name of Father:
***( First, Middle, Last name)***

20. Name of Mother:
(***First, Middle, Maiden Last name***)

21. Name of immediate next of kin: _____
Address: _____
City/State/Zip: _____
Phone #: ( ) _____ **Relationship**:_____

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) | **Name and Relationship** | Complete Address | Phone |
| 3rd Relative / or Close Family Friend | **Name and Relationship** | Complete Address | Phone |