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 603, 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. #:

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 America
[ ] 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 give her maiden name)

13. Your main occupation currently or <u>when</u> you were working: ***(do not enter retired)***

14. Type of business or industry:

15. Name and locality (town/state) of company/firm identified in 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**	**Relationship**	Complete Address	Phone
3rd Relative / or Close Family Friend	**Name**	**Relationship**	Complete Address	Phone