

**Certificate of Donation**

I hereby offer the use of my body after death for educational or scientific purposes to **Willed Body Program** of the University of Arizona College of Medicine. If the body is accepted by the Willed Body Program of the University of Arizona, it shall be used by the University for educational or scientific purposes as determined by the University. Unless specifically forbidden by the donor, such use may include transporting the body to an institution other than the University of Arizona (within the State of Arizona only) for purposes of education and/or research. Failure to agree to such alternate transport may reduce the possibility that the body will be accepted by the department. Upon completion of the use by either the University of Arizona or other receiving institution (typically 18 months to two years), the body shall be cremated individually and the cremated remains may be returned to the family. **Under no circumstances will uncremated remains be returned.**

If permanent arrangements for final disposition of my cremated remains are to be carried out by the person or establishment (or authorized representative) designated to receive the cremated remains and have not been completed within 90 days after the date of notification of availability of cremated remains for disposition, I authorize the Willed Body Program to dispose of the cremated remains in any manner it deems suitable. I understand that the person so designated (or an authorized representative) may either pick up the cremated remains from the Willed Body Program in Tucson in person or have the cremated remains shipped by the U.S. Postal Service Registered Mail. There will be no charge for return of cremated remains.

Witnesses to Donor's Signature:

\_\_\_\_\_  
Signature of Donor

\_\_\_\_\_  
Signature of Witness #1

\_\_\_\_\_  
Name of Donor (Print or Type)

\_\_\_\_\_  
Signature of Witness #2

\_\_\_\_\_  
Date

\_\_\_\_\_ I agree to the permanent preservation of any organ or skeletal material for educational purposes, **with no return of cremated remains**. Initial **only** if you do not request return of cremated remains on page 2 of this Certificate.  
(initial here if desired)

Please make photocopies of this Certificate of Donation for your records and for distribution to those who need to be aware of your intent to donate your body to the University of Arizona. Do not place your copy of this document in a safe deposit box. **Return the original signed copy of this Certificate** to the Willed Body Program, P.O. Box 245045, Tucson, AZ 85724-5045.

The purpose of acceptance of this document for filing by The University of Arizona is to provide convenience of access to the document. Acceptance of the document does not imply commitment to accept the body named herein. Acceptance of a body by The University of Arizona is contingent upon circumstances of death and usability of the body for the University's purposes.

Because bodies willed to this program are used mainly in the education of physicians, and to a minor extent in research, the value of a body is greatly diminished if all parts are not intact. An exception to this is that the cornea (but not the whole eye) may be donated to an eye bank through a separate willing process. The University of Arizona cannot guarantee the acceptance of a willed body. A body may not be acceptable if any of the following conditions are present:

1. Removal of major organs or parts for transplant purposes (other than corneas) or major surgery near the time of death. Bodies that have undergone hysterectomy, prostate surgery, mastectomy, etc., are acceptable.
2. Obesity.
3. Decomposition of the body prior to embalming.
4. Severe trauma, such as autopsy or death from drowning, burning, homicide, suicide, or motor vehicle accident.
5. Contagious diseases, especially viral, such as virulent herpes, MRSA, hepatitis, or HIV, but also other drug-resistant diseases and dementias of the Creutzfeldt-Jacob type.

In summary, the University of Arizona reserves the right to refuse any body which is, in its opinion, unfit for use or which for other reasons it cannot use. The donor may revoke this document at any time simply by statement of intent.

**Next of Kin Contact Information:**

Name of Next of Kin or Executor of Estate (Please print) \_\_\_\_\_

Relationship to Donor (Please print) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

Email address \_\_\_\_\_

**Alternate Contact Information:**

Name of Contact Person (Please print) \_\_\_\_\_

Relationship to Donor (Please print) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

Email address \_\_\_\_\_

**Return of Cremated Remains:** (Complete **only** if you have not initialed the section on page 1 to donate for permanent preservation.)

Unless designated by the donor for permanent preservation by the University, please return my cremated remains to the following individual upon completion of anatomical study. The recipient (or authorized representative) may pick up the cremated remains from the Willed Body Program at the College of Medicine in Tucson or have the cremated remains returned using U.S. Postal Service Registered Mail. There is no charge for return of cremated remains. If no recipient is designated, the Willed Body Program is authorized to dispose of the cremated remains in any manner it deems suitable. If permanent arrangements for final disposition of my cremated remains are to be carried out by the designated recipient and have not been completed within 90 days after the date of notification of availability of cremated remains, it may not be possible to return them.

**Designated recipient:**

\_\_\_\_\_  
Name of Recipient (Please print)

\_\_\_\_\_  
Relationship to Donor (Please print)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Email Address

**PERSONAL INFORMATION PERTINENT TO BODY DONATION**

**Date:** \_\_\_\_\_ **Telephone Number:** (\_\_\_\_) \_\_\_\_\_

**1. Full name of donor (print):** \_\_\_\_\_

Check one:  Male  Female (First) (Full Middle Name) (Last)

**2. Present address:** \_\_\_\_\_  
(Street Address)

(City) (State) (Zip)

**3. Within city limits?** (Check one)  Yes  No

**County of residence:** \_\_\_\_\_

On a reservation? (Check one)  No  Yes If "Yes," specify: \_\_\_\_\_

**4. Place of birth:** \_\_\_\_\_  
(City) (State) (If not USA, what country?)

**5. Date of birth:** \_\_\_\_\_  
(Month) (Day) (Year)

**6. Citizen of what country?** \_\_\_\_\_

**7. Year donor began permanent residency in Arizona:** \_\_\_\_\_

**8. Place of residence (State) before moving to Arizona:** \_\_\_\_\_

**9. Current marital status:** (Check one)  Never Married  Married  
 Widowed  Divorced

**10. If married, donor's wife's full maiden name:** \_\_\_\_\_  
(First) (Full Middle Name) (Last Name Before Marriage)

**or** donor's husband's full name: \_\_\_\_\_  
(First) (Full Middle Name) (Last)

**11. Donor's father's full name:** \_\_\_\_\_  
(First) (Full Middle Name) (Last)

**12. Donor's mother's full maiden name:** \_\_\_\_\_  
(First) (Full Middle Name) (Last Name Before Marriage)

**13. List the one occupation engaged in by donor:** \_\_\_\_\_

**14. In what business or industry was this occupation?** \_\_\_\_\_

**15. What is the highest grade level of education completed?** \_\_\_\_\_

**16. Donor's Social Security Number:** \_\_\_\_\_

**17. Veteran?** (Check one)  No  Yes **Branch of Service:** \_\_\_\_\_

**18. Ethnicity?** (Check one)  
 White  Black  American Indian (Specify tribe: \_\_\_\_\_)  
 If Hispanic:  Mexican;  Spanish;  Puerto Rican;  Cuban;  Other (Specify: \_\_\_\_\_)  
 Asian  Other (Specify: \_\_\_\_\_)

Return completed forms to:  
Willed Body Program, P.O. Box 245045, Tucson, AZ 85724-5045

## MEDICAL QUESTIONNAIRE

**Date:** \_\_\_\_\_ **Telephone No.** \_\_\_\_\_

**Your Full Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Surgical History:** \_\_\_\_\_

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**Major Health Problems:** \_\_\_\_\_

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**Deformities or Amputations:** \_\_\_\_\_

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