DENTISTRY

TEXAS A&M UNIVERSITY

Anatomical Gift Program | Department of Biomedical Sciences

3302 Gaston Avenue | Dallas, TX 75246

214.828.8276| Fax 214.874.4538

DONATION OF FAMILY MEMBER'S BODY FOR MEDICAL/DENTAL SCIENCE

In accordance with the desires of my family member, ____,

FIRST NAME MIDDLE NAME LAST NAME

to whom I am related as ________________________, I authorize the Anatomical Board of the State of Texas to use his/her

RELATIONSHIP

body for medical and dental research and teaching.

It is my desire that my family member's body be assigned to Texas A&M School of Dentistry, 3302 Gaston Ave., Dallas, TX 75246. However, to assure that maximum benefit is derived from this contribution, I authorize the Anatomical Board to transfer his/her body to other teaching or research institutions within the State of Texas if the College of Dentistry does not have a need for his/her body at the time of death. Moreover, I authorize the Anatomical Board of the State of Texas to transport the donated body out of the State of Texas in the event that the holding institution and the Secretary-Treasurer have determined that an excess of bodies exist at that time in the State of Texas.

I understand that the **Anatomical Gift *Program at the school should be notified immediately (214-828-8276)*** of my family member's death, so that appropriate arrangements can be made. Staff will schedule transport for my family member's body.

I understand that under a few circumstances, my family member's body may not be accepted at the time of death, and in that event, his/her survivors will need to make other arrangements for the final disposition of the body, and the Willed Body Program is not responsible for any costs associated with other arrangements. I understand that ***if he/she has a contagious disease, if the body is damaged by violence at death, if an autopsy is performed, if he/she commits suicide, if the body is embalmed, if organs or parts are removed for transplantation or otherwise, or if the body weight is over acceptable limits,*** his/her body may not be acceptable to the Willed Body Program. If the body is accepted, I authorize release of pertinent radiographs and information from my family member's medical records to officials at the institution named above for the purpose of enhancement of the use of his/her body in medical/dental education and research.

I understand that the school is obligated to pay only standard fees for the embalming and transportation of my family member's body a distance of 250 miles or less from the institution. If his/her death should occur at a greater distance from the institution, ***I understand I must make the necessary transportation and payment arrangements*** or locate a closer institution approved by the Anatomical Board where the body can be delivered.

I hereby relinquish all rights and claims regarding my family member's body and direct that in accepting and using his/her body for scientific purposes, and in the final disposition of the body, neither the Anatomical Board of the State of Texas nor the receiving institution shall incur any liability, and no claim shall arise against that institution in any manner. I understand that complaints or inquiries regarding a willed or donated body should be directed to the Secretary-Treasurer of the Anatomical Board of Texas. The name and address of this individual may be obtained from the college and is listed in the Texas State Telephone directory.

Date: _____________ Signature of relative or agent: ____

Printed name: ____

Address: ____

NUMBER AND STREET CITY STATE ZIP

Home phone:_______________ Work phone:_______________ Cell phone: _______________

I, the undersigned witness, hereby certify that I am over 21 years of age on this date and that I have witnessed the above signature. (Signatures and addresses of two (2) witnesses required.)

WITNESS' SIGNATURE	WITNESS' SIGNATURE
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
PHONE	PHONE

PERSONAL DATA

PLEASE PRINT OR TYPE

The following personal information about the donor will facilitate recording of the death certificate.

Date: ____________________________ Social security #:________________________________

Donor's name: ____
FIRST MIDDLE LAST (MAIDEN)

Donor's address: ____
NUMBER AND STREET CITY STATE ZIP COUNTY

Date of birth:___________________________________ Place of birth:___________________________

Gender: ☐Male ☐Female Marital status: ☐Married ☐Never married ☐Divorced ☐Widowed

Spouse's name: ____
FIRST MIDDLE LAST (MAIDEN)

Father's name:____
FIRST MIDDLE LAST

Mother's name:____
FIRST MIDDLE LAST (MAIDEN)

Occupation when working (do not use retired): ___________________________ Type of business: ________________

U.S. Veteran: ☐Yes ☐No Branch of military service: ___________________________ Serial #: ___________

Peace officer for the State of Texas: ☐Yes ☐No Height: ____________ Weight: _________________

Have you ever been diagnosed with a contagious disease? ☐Yes ☐No If yes, which one(s)? _________________

List organs removed by surgery: ____

Education: (Optional)
Check highest degree or level of school completed

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate's degree (AA, AS)
- ☐ Bachelor's degree (BA, AB, BS)
- ☐ Master's degree (MA, MS, MEng, Med,MSW, MBA)
- ☐ Doctorate (PhD, EdD) or professional degree (MD, DDS, DVM, LLB, JD)

Of Hispanic Origin? (Optional)
Check the one that best describes you.
Check "No" if you are not Spanish/Hispanic/Latino

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)_______________________
  ____

Race: (Optional)
Check one or more races to indicate what you consider yourself to be

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
  (Specify name of tribe) ___________________
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify)___________________
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander (Specify)_____________
- ☐ Other (Specify)_________________________

Contact information for nearest relative or agent:

Name: ____ Relationship: ____________________

Address: ______________________________________ City, state, zip ______________________________

Home phone:_____________________ Work phone:_____________________ Cell phone: ____________________

Cremation:

It is my understanding that the final disposition of my family member's body shall be cremation, which may occur up to two years after Texas A&M College of Dentistry receives his/her body.

☐ **I do not** wish to have the ash remains returned to the family.

☐ **I wish** to have the ash remains returned to the person listed below. I understand I will need to keep their contact information updated.

Name: ____ Relationship to donor: ____________________

Address: ____

Home phone:_____________________ Work phone:_____________________ Cell phone: ____________________

Relative's or agent's signature: ____