CERTIFICATE FOR BEQUEATHING BODY

TO WHOM IT MAY CONCERN: I hereby authorize that my body, after death, be given to the Department of Medical Education/Body Donation Program at the University of Cincinnati College of Medicine for the purpose of aiding medical science, which may include testing for HIV and Hepatitis 1 and 2.

NAME _____ SSN: _____ - _____ - _____ DATE OF BIRTH _____
(Please Print or Type Full Name)

ADDRESS _____
Street City State Zip Code

PLACE OF BIRTH _____ RACE ___ YEARS OF SCHOOLING _____

U.S. ARMED FORCES _____/_____/_____
Branch Mo/Yr Inducted Mo/Yr Discharged

FATHER'S NAME _____ MOTHER'S NAME _____
(Please include Mother's Maiden Name)

DONOR'S OCCUPATION _____ TYPE OF BUSINESS_____
(**Prior to Retirement**)

MARITAL STATUS (circle one): SPOUSE NAME_____
Married Divorced Separated Widowed Never Married (**if wife, include maiden name**)

_____ _____
SIGNATURE OF DONOR (Must be the DONOR) **Date**

Signed by the donor in the presence of **2 non-related witnesses** on this day ____in the month of _____ 20___

WITNESSES:

NAME _____ NAME _____
WITNESS SIGNATURE **WITNESS SIGNATURE**
ADDRESS _____ ADDRESS _____

_____ _____
City State Zip City State Zip

Death Away from Home:
If a donor dies some distance from home, the College of Medicine will provide the donor's family with the name of the nearest medical college. We cannot, however, guarantee that the body will be accepted at that location.

Cremains (ashes): (Choose one)
Upon completion of medical studies (1-4 years), the body is individually cremated. Please choose the final disposition of your remains.
_____ I would like the UC College of Medicine to **save** my ashes and advise my survivors when they are available.
_____ I would like the UC College of Medicine to **bury** my ashes at their burial site

Utilization at Another Institution:
The University of Cincinnati makes donated bodies available for medical education, the advancement of medical science, and research for the development of medical products and techniques. This includes making donated bodies available to outside researchers and other institutions.

TO BE SIGNED BY NEXT OF KIN: I, being next of kin to _____, do hereby agree to his/her desire after death to be utilized to aid medical science. I realize the only expense to this program is transportation cost, and I will be responsible for arranging this along with payment with the appropriate funeral home and/or ambulance service.

NAME _____ RELATIONSHIP _____

ADDRESS _____
Street City State Zip

PHONE NUMBER(s): Home _____ Work _____ _____
SIGNATURE (Next of Kin)

Make as many copies of the completed form as you need and return the original to UC

************A COPY OF THIS FORM MUST ACCOMPANY THE BODY************

Revised 10/2018