PLEASE RETURN TO: P.O. BOX 1749, PORTLAND, OR 97207 PH: 1 – 844 – 330 – 7040 FAX: 1 – 844 – 330 – 7040 EMAIL: CONTACT@AETERNITAS.COM

AETERNITAS LIFE

DONOR HISTORY ASSESSMENT

This form to be completed by authorizing person. Please confirm that all information is correct and legible. The following set of questions are asked in order to protect the health and safety of the medical professionals preparing the donation as well as the educators, researchers and students that may handle the anatomical gifts. Inaccurate, illegible or missing information will delay or void the donation. If information is unknown, write, "UNKNOWN." For assistance in completing this form, call 1-844-330-7040.

Donor name:*	Donor driver license:*
Authorizing person:*	Relationship to donor:*
Address:*	Phone number:*

Designated (informant) person:*	Relationship to donor:*
Address:*	Phone number:*

Donor take any prescription or anticoagulant drugs?*	No ☐ Yes ☐ Specify:
Donor take any intravenous or recreational drugs?*	No ☐ Yes ☐ Specify:
Donor take any radioactive drugs or treatment?*	No ☐ Yes ☐ Specify:
Donor tested positive for HIV or hepatitis B and C?*	No ☐ Yes ☐ Specify:
Donor tested positive for prion disease or parasites?*	No ☐ Yes ☐ Specify:
Donor tested positive for MRSA, VRE, TB or sepsis?*	No ☐ Yes ☐ Specify:

The following questions are asked in order to obtain the relevant medical and social history so that the donation can be applied to the appropriate uses for research and education. If information is unknown, write, "UNKNOWN." The questions are not exhaustive, provide detailed information to ensure the efficacy and safety of the donation.

Donor have history of surgery, transplant or implants?*	No ☐ Yes ☐ Specify:
Donor have history of dentures or dental implants?*	No ☐ Yes ☐ Specify:
Donor have history of cancer or diabetes?*	No ☐ Yes ☐ Specify:
Donor have history of lung, heart or renal disease(s)?*	No ☐ Yes ☐ Specify:
Donor have history of degenerative brain disease(s)?*	No ☐ Yes ☐ Specify:
Donor have history of degenerative bone disease(s)?*	No ☐ Yes ☐ Specify:
Donor have history of autoimmune disease(s)?*	No ☐ Yes ☐ Specify:
Donor have history of hypertension, high cholesterol?*	No ☐ Yes ☐ Specify:
Donor have history of smoking or alcohol use?*	No ☐ Yes ☐ Specify:
Donor have history of tattooing or body piercing(s)?*	No ☐ Yes ☐ Specify:
Donor have history of long-term homelessness?*	No ☐ Yes ☐ Specify:
Donor have history of skin lesions or necrosis?*	No ☐ Yes ☐ Specify:
Donor have history of edema or jaundice?*	No ☐ Yes ☐ Specify:
Donor registered for physician assisted death?*	No ☐ Yes ☐ Specify:

OFFICIAL			
	Representative/affiliation obtaining authorization:	Phone number:	
	Signature/license no. of representative:	Date:	Time:

OFFICIAL				
	Recorded by:	Method:	Date:	Time:
	Verified by:	Method:	Date:	Time: