



**AUTHORIZATION FOR ANATOMICAL DONATION AND CREMATION**

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

I wish to register the donor for anatomical donation and cremation, for the purposes of research and education. A document of gift authorizes the postmortem release of the donor's medical records and any examination necessary to ensure the acceptability of the anatomical gift, including the cremation and disposition of the donor's remains after anatomical donation.

	<b>Authorization for Anatomical Donation</b>		<b>Authorization for Cremation</b>
<b>ORS 97.955</b>	<b>Persons Authorized to Make Anatomical Gift During the Life of the Donor</b> (Check the highest priority class possible, or skip if authorized by 97.955)  <input type="checkbox"/> 1. The donor, if the donor is an adult or a minor and is emancipated <input type="checkbox"/> 2. An agent of the donor (ex. power of attorney for health care) <input type="checkbox"/> 3. Both parents of the donor, if the donor is an unemancipated minor	<b>ORS 97.130(1)</b>	<b>Right to Control Disposition of Remains (During the Life of the Donor)</b> (Check the highest priority class possible, or skip if authorized by 97.130(2))  <input type="checkbox"/> 1. The donor, if the donor is an adult or a minor and is emancipated <input type="checkbox"/> 2. An agent of the donor (ex. power of attorney for health care) <input type="checkbox"/> 3. Both parents of the donor, if the donor is an unemancipated minor
<b>ORS 97.965</b>	<b>Persons Authorized to Make Anatomical Gift on Behalf of a Decedent</b> (Check the highest priority class possible, or skip if authorized by 97.965)  <input type="checkbox"/> 1. An agent of the decedent (ex. durable power of attorney) <input type="checkbox"/> 2. The spouse of the decedent <input type="checkbox"/> 3. An adult child(ren) of the decedent <input type="checkbox"/> 4. Both parents of the decedent <input type="checkbox"/> 5. An adult sibling(s) of the decedent	<b>ORS 97.130(2)</b>	<b>Right to Control Disposition of Remains (on Behalf of a Decedent)</b> (Check the highest priority class possible, or skip if authorized by 97.130(1))  <input type="checkbox"/> 1. An agent of the decedent (ex. durable power of attorney) <input type="checkbox"/> 2. The spouse of the decedent <input type="checkbox"/> 3. A son(s) or daughter(s) of the decedent 18 years of age or older <input type="checkbox"/> 4. Both parents of the decedent <input type="checkbox"/> 5. A brother(s) or sister(s) of the decedent 18 years of age or older

<b>ORS 438.715(4)</b>	<b>Costs and Services that are Responsibility of the Authorizing Person</b> (Check the optional add-on services authorized by the authorizing person)  The authorizing person must pre-pay for optional services by credit or debit card before acceptance of the donor in the service area. Services may not be available in all states.  <input type="checkbox"/> Brain preservation (pre-registration required) <input type="checkbox"/> Aqua cremation (alkaline hydrolysis) <input type="checkbox"/> DNA preservation, return by USPS registered mail to: Recipient: _____ Phone number: _____ Address: _____
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<b>ORS 97.150</b>	<b>Disposition of Cremated Remains*</b>  The human remains of the donor will be cremated by a licensed crematorium selected by Aeternitas Life. Per ORS 438.715(2), any cremated remains returned to a recipient in a cardboard or plastic urn will not include the cremated remains of the anatomical gifts recovered for research and education.  <input type="checkbox"/> Do not return cremated remains, scatter remains <input type="checkbox"/> Pick up cremated remains at crematory <input type="checkbox"/> Return cremated remains by USPS registered mail to: Recipient: _____ Phone number: _____ Address: _____
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By signing this record I swear and affirm that I am the donor, their agent or legal next of kin or are otherwise empowered to execute this authorization according to all state and local laws and bear all responsibility thereof. I swear and affirm that I am aware of no objection to this anatomical donation and cremation by the spouse, any adult child, parent, sibling, adult grandchild, grandparent or guardian, or of provision of any will or instructions made by the decedent. I swear and affirm that the information entered herein is true and correct to the best of my knowledge:

Authorizing person signature:*	Date:*	Time:*
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Pursuant to ORS 97.953(6), (a) "disinterested witness" means a witness other than: (A) A spouse, child, parent, sibling, grandchild, grandparent or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift; or (B) An adult who exhibited special care and concern for the individual. (b) Disinterested witness does not include a person to whom an anatomical gift could pass under ORS 97.969. Pursuant to ORS 97.957, (2) if the donor or other person authorized to make an anatomical gift under ORS 97.955 is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must: (a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and (b) state that it has been signed and witnessed as provided in paragraph (a) of this subsection.

Witness one:*	Phone number:*	
Witness one signature:*	Date:*	Time:*

Witness two:*	Phone number:*	
Witness two signature:*	Date:*	Time:*

<b>OFFICIAL</b>	Recorded by:	Date:	Time:
	Verified by:	Date:	Time:



**DEATH CERTIFICATE WORKSHEET**

This form to be completed by authorizing person. Please confirm that all information is correct, legible and matches legal records. Inaccurate, illegible or missing information will delay or void the official death certificate. 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 legal name:*			Maiden name:*	
Sex:*	Age:*	Height:*	Weight:*	SSN:*
Hispanic origin? (yes/no)*		Race(s):*		Education level:*

Birthplace (city, state or country):*			DOB:*	
Current address:*			City:*	State:*
County:*	Inside city limits? (yes/no)*		Years at address:*	

U.S. military service? (yes/no)*		Specify (branch, combat service):*		
Occupation (before retiring):*		Industry:*	Years in occupation:*	
Last employer address:*			Employer name:*	

Marital status (circle):*      Married      Legally separated      Widowed      Divorced      Never married      Unknown						
Spouse's name (and maiden name):*				Deceased?*		
Mother's name (and maiden name):*				Deceased?*		
Father's name:*				Deceased?*		

Hospital or hospice care? (yes/no)*		Specify (facility name, length of time):*			
Address of facility:*				Phone number:*	
Place of death: (hospital/home)*		Specify (location, stairs):*			
Address of death:*				County of death:*	

Primary physician:*			Phone number:*	
Physician assisted death? (yes/no)*		Cause of death:*	DOD:*	Time:*

Notes:				

<b>OFFICIAL</b>	Recorded by:	Date:	Time:
	Verified by:	Date:	Time:



**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 technicians preparing the anatomical donation as well as the technicians 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 <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor take any intravenous or recreational drugs?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor take any radioactive drugs or treatment?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor tested positive for HIV or hepatitis B and C?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor tested positive for prion disease or parasites?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor tested positive for MRSA, VRE, TB or sepsis?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:

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

Donor have history of surgery, organ transplant?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of spine or joint implants?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of dentures or dental implants?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of missing teeth (out of 32)?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of cancer or diabetes?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of lung, heart or renal disease?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of degenerative brain disease?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of degenerative bone disease?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of autoimmune disease?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of vascular hypertension?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of smoking or alcohol use?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of tattooing or body piercing?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of homelessness, incarceration?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of skin lesions or necrosis?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of edema or jaundice?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of vasectomy or hysterectomy?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor have history of pacemaker or brain implant?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Donor registered for physician assisted death?	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:

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



**FINAL DISPOSITION ADDENDUM**

If there is more than one member of a class listed in ORS 97.965 and ORS 97.130(2) entitled to authorize the anatomical donation and cremation on behalf of a donor, please list their information below. For assistance in completing this form, call 1-844-330-7040.

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

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Address:		Phone number:	

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Signature:		Date:	Time:
Address:		Phone number:	

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Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

Print name:		Relationship to donor:	
Signature:		Date:	Time:
Address:		Phone number:	

<b>OFFICIAL</b>	Recorded by:	Date:	Time:
	Verified by:	Date:	Time: