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

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.

ORS 97.955 — ***Authorization for Anatomical Donation***

Persons Authorized to Make Anatomical Gift During the Life of the Donor
(Check the highest priority class possible, or skip is authorized by 97.965)

- ☐ 1. The donor, if the donor is an adult or a minor and is emancipated
- ☐ 2. An agent of the donor (ex. power of attorney for health care)
- ☐ 3. Both parents of the donor, if the donor is an unemancipated minor

ORS 97.130(1) — ***Authorization for Cremation***

Right to Control Disposition of Remains (During the Life of the Donor)
(Check the highest priority class possible, or skip if authorized by 97.130(2))

- ☐ 1. The donor, if the donor is an adult or a minor and is emancipated
- ☐ 2. An agent of the donor (ex. power of attorney for health care)
- ☐ 3. Both parents of the donor, if the donor is an unemancipated minor

ORS 97.965

Persons Authorized to Make Anatomical Gift on Behalf of a Decedent
(Check the highest priority class possible, or skip if authorized by 97.955)

- ☐ 1. An agent of the decedent (ex. durable power of attorney)
- ☐ 2. The spouse of the decedent
- ☐ 3. An adult child(ren) of the decedent
- ☐ 4. Both parents of the decedent
- ☐ 5. An adult sibling(s) of the decedent

ORS 97.130(2)

Right to Control Disposition of Remains (on Behalf of a Decedent)
(Check the highest priority class possible, or skip if authorized by 97.130(1))

- ☐ 1. An agent of the decedent (ex. durable power of attorney)
- ☐ 2. The spouse of the decedent
- ☐ 3. A son(s) or daughter(s) of the decedent 18 years of age or older
- ☐ 4. Both parents of the decedent
- ☐ 5. A brother(s) or sister(s) of the decedent 18 years of age or older

ORS 438.715(4)

Costs and Services that are Responsibility of the Authorizing Person
(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.

☐ Brain preservation (pre-registration required) ☐ Aqua cremation (alkaline hydrolysis) ☐ DNA preservation, return by USPS registered mail to:

Recipient: _____ Phone number: _____
Address: _____

ORS 97.150

*Disposition of Cremated Remains**

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.

☐ Do not return cremated remains, scatter remains ☐ Pick up cremated remains at crematory ☐ Return cremated remains by USPS registered mail to:

Recipient: _____ Phone number: _____
Address: _____

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:*

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:*

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

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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:

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

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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 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 ☐ 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 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 ☐ Yes ☐ Specify:
Donor have history of spine or joint implants?	No ☐ Yes ☐ Specify:
Donor have history of dentures or dental implants?	No ☐ Yes ☐ Specify:
Donor have history of missing teeth (out of 32)?	No ☐ Yes ☐ Specify:
Donor have history of cancer or diabetes?	No ☐ Yes ☐ Specify:
Donor have history of lung, heart or renal disease?	No ☐ Yes ☐ Specify:
Donor have history of degenerative brain disease?	No ☐ Yes ☐ Specify:
Donor have history of degenerative bone disease?	No ☐ Yes ☐ Specify:
Donor have history of autoimmune disease?	No ☐ Yes ☐ Specify:
Donor have history of vascular hypertension?	No ☐ Yes ☐ Specify:
Donor have history of smoking or alcohol use?	No ☐ Yes ☐ Specify:
Donor have history of tattooing or body piercing?	No ☐ Yes ☐ Specify:
Donor have history of homelessness, incarceration?	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 have history of vasectomy or hysterectomy?	No ☐ Yes ☐ Specify:
Donor have history of pacemaker or brain implant?	No ☐ Yes ☐ Specify:
Donor registered for physician assisted death?	No ☐ Yes ☐ Specify:

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

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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:
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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:	

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