THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Division of Anatomy
Body Donation Program
279 Hamilton Hall
1645 Neil Avenue
Columbus, OH 43210
Phone: 614-292-4831 ♦ Fax: 614-292-7659
E-mail: bodydonor@osumc.edu
Website: http://go.osu.edu/bodydonation

Anatomical Bequeathal Form

(Please retain a copy of this form for your records.)

Instructions: (Please print or type): Complete the entire form, including appropriate signatures, and return the original form to the address listed above.

PART A:

Name: SSN:

(Title) (Last) (First) (Middle)

Street: City: State: Zip:

County: Home Phone: Cell Phone:

Email: Date of Birth (MM/DD/YYYY): ◯Male ◯Female

Marital Status: ◯Never Married ◯Married ◯Widowed ◯Divorced

Next of Kin: (order of legal descent: spouse, children, parents, siblings)

Name Relationship:

(Title) (Last) (First) (Middle)

Street: City: State: Zip:

Home Phone: Cell Phone: Email:

PART B: Cremains to be returned? ◯No ◯Yes If Yes, complete the following:

Name: Relationship:

(Title) (Last) (First) (Middle)

Street: City: State: Zip:

Home Phone: Cell Phone: Email:

PART C:

I have read, understand, and agree to the conditions for donation of my body to The Ohio State University Body Donation Program **as stated on page two**. I further understand and agree that acceptance of my body into the Program will be determined at the time of my death and that the Body Donation Program reserves the right to refuse any donation. By signing below I am also giving authorization to release my medical records to the Division of Anatomy.

Signature of Donor/Guardian/Medical or Health Care POA* Date

Signature of Next of Kin Date

Signature of Witness Date

Three (3) different individual's' signatures are required. Notary is unnecessary.

* If a **Medical/Health Care Power of Attorney (POA)** is signing for a Donor, please include a copy of the applicable POA form.

Please INITIAL EACH blank line to indicate agreement to that condition.

1. _____ I understand that The Ohio State University Body Donation Program will **only** be responsible for the cost of: transporting my remains from place of death to the program, death certificate preparation fee, and cremation, as well as the return or entombment of the cremains for all donors accepted into the program**.**

2. _____ I understand the decision to accept my body will not be determined until the event of my death.

3. _____ The acceptance of these forms does not constitute a contract with The Ohio State University Body Donation Program.

4. _____ I understand the following restrictions may prevent the acceptance of my body:

   A. Contagious disease (HIV, Hepatitis, TB, Creutzfeldt-Jakob disease, any hospital acquired disease, including MRSA and Clostridium difficile, etc.)
   B. Extreme emaciation, obesity, or body contractures
   C. Severe trauma or open wounds (including certain recent surgeries)
   D. Ascites, edema, or septicemia
   E. Removal of organs or body parts, except eyes, at time of death
   F. Current need of education or research programs for donors

5. _____ I understand that the Body Donation Program will **not** release a report to family members pertaining to our educational or research findings.

6. _____ I understand that I am responsible for sharing my decision to donate and all policies of the program with my family.

7. _____ I understand that it is my responsibility to contact the Program with any information to be updated (change of address, next of kin designation, marital status, etc.) for my donation to remain current.

8. _____ I understand that I may withdraw from the Program at any time by sending a signed and dated letter to the Program. A letter of confirmation from the Program will be returned.

9. _____ I understand that the exact use of my anatomical gift will be at the discretion of the Program. I understand that my body may be used for education, general research, or to further innovative technologies. In some cases such investigation may involve exposures to damaging forces (e.g., impacts, crashes, ballistic injuries, blasts). Examples of how the gift might be used include educational and training programs, (e.g., pathology, engineering, anthropology, taphonomy including canine training and forensics), vehicle safety or the development of protective equipment (e.g., sports, military, law enforcement).

10. _____ I understand my body may be used by The Ohio State University Body Donation Program or by other health centers or educational or research institutions approved by The Ohio State University Body Donation Program.

11. _____ I authorize my name to be disclosed at the annual Anatomy Memorial Service.

12. _____ I give permission, upon my death and acceptance into the Body Donation Program (BDP), to the BDP to confirm my donation when requested by media entities.

13. _____ **In the event that my donation is accepted at the time of death, I understand that my decision as evidenced here whether or not to have my cremains returned is final.**

14. _____ Final disposition of the cremated remains **(check only one)**:

○ *Do not return cremains (common burial).* Cremains that are not returned will be entombed, at the program's expense, in the mausoleum at the Silent Home Cemetery, 1576 Lancaster Ave., Reynoldsburg, OH 43068. Families are welcome to visit any time the cemetery is open.

-OR-

○ *Return cremains to the party indicated on page one.* **I understand that by agreeing to the terms of this program that some of cremains may not be returned. The Body Donation Program reserves the right to retain part of the donation for future educational and/or research purposes and these will not be returned.**

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Division of Anatomy
Body Donation Program
279 Hamilton Hall
1645 Neil Avenue
Columbus, OH 43210
Phone: 614-292-4831 ♦ Fax: 614-292-7659
E-mail: bodydonor@osumc.edu
Website: http://go.osu.edu/bodydonation

Cremation Authorization Form

NAME OF DONOR _____

Please INITIAL EACH blank to indicate you have read and agree with the statement.

1. _____ ◯ I have; ◯ do not have; a pacemaker, or any other device or implant that may pose a hazard to the health or safety of crematory personnel. Please describe the device if applicable: _____
2. _____ I understand the crematory will cremate the container in which the remains are delivered to the crematory.
3. _____ I understand that the remains will be cremated separate from any other donor.
4. _____ I understand that no one other than crematory personnel may be present in the holding room or cremation room prior to or during cremation, or during the removal of the cremains from the chamber.
5. _____ I understand that after cremation, the cremains will be processed according to the practice of the crematory. Such processing includes removal of foreign matter (especially metal from clothing, from dental work, or from containers) which remains after cremation. Some small pieces, however, may escape human detection and be included in the cremated remains.
6. _____ I understand that although the crematory will take reasonable efforts to remove all of the cremains from the cremation chamber, it is impossible to remove all of them.
7. _____ The crematory will perform the cremation of the donor at a time and date as its work schedule permits and without notification to the agent.
8. _____ The Authorizing Agent acknowledges that OSU Division of Anatomy and the crematory facility are relying upon the information and statements being provided by the person(s) in this authorization. I certify that all of the information and statements contained in this authorization form are accurate and no omissions of any material fact have been made.
I agree to indemnify and hold harmless OSU Division of Anatomy and the crematory facility, their officers, directors, employees and agents from any and all claims, demands, actions, causes of action or suits of any kind or nature whatsoever, including, but not limited to, any legal fees arising out of or resulting from OSU Division of Anatomy's and the crematory facility's reliance on or performance consistent with the directions, statements, representations and agreements contained in this authorization, to the full extent of any, and all applicable, statutory immunity provided in Rev. Code 4717.30.
9. _____ The final disposition of the cremated remains are:
   ◯ To be returned to _____
   ◯ **NOT** to be returned (common burial). The Program will be responsible for the cost of entombment.

Signature of Donor/Guardian/POA*: _____ Date: _____

Signature of Witness: _____ Date: _____

Donor's Address: _____

* If a **Medical/Health Care Power of Attorney (POA)** is signing for a Donor, please include a copy of the applicable POA form.

Revised 10/4/2021

CLEAR FORM

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Division of Anatomy
Body Donation Program
279 Hamilton Hall, 1645 Neil Avenue
Columbus, OH 43210
614-292-4831 Phone 614-292-7659 Fax
http://go.osu.edu/bodydonation

Information for Death Certificate

Donor's Full Name: _____
First, Middle, and Last; Include Suffix (e.g., Jr., Sr., II, III) (As it Appears on Social Security Card)

Social Security Number: _____ **Gender:** ☐ *Male* ☐ *Female*

Date of Birth: _____ **Place of Birth:** _____
Month, Day, and Year *City and State or Foreign Country*

Current Address: _____ **County:** _____
Street, City, State, and Zip Code; if P.O. Box, include the physical address

Phone: _____ **E-Mail:** _____

Veteran of the U.S. Armed Forces? ☐ ***No*** ☐ **Army** ☐ **Navy** ☐ **Marines** ☐ **Air Force** ☐ **Coast Guard**

Date of Entry into Service (MM/DD/YYYY): _____

Date of Discharge/Separation (MM/DD/YYYY): _____

Type of Discharge/Separation (Select One): ☐ *Honorable* ☐ *General Under Honorable Conditions* ☐ *Other Than Honorable* ☐ *Dishonorable* ☐ *Medical / Entry-Level*

Current Marital Status (Select One): ☐ *Never Married* ☐ *Married* ☐ *Widowed* ☐ *Divorced* ☐ *Separated*

Spouse's Full Name: _____ **Maiden:** _____
First, Middle, and Last; Include Suffix (e.g., Jr., Sr., II, III) *Last Name Prior to First Marriage*

Highest Level of Education (Check ONE of the Following)

☐ 8th Grade or Less
☐ 9th Through 12th Grade, No Diploma
☐ High School Diploma or GED
☐ Some College But No Degree
☐ Associates Degree (e.g., AA, AS)
☐ Bachelors Degree (e.g., BA, BS)
☐ Masters Degree (e.g., MA, MS)
☐ Doctorate or Professional Degree

Hispanic Origin? ☐ *Yes* ☐ *No* **Race:** _____

Occupation (Prior to Retirement): _____

Father's Full Name: _____
Even if Deceased; First, Middle, and Last; Include Suffix (e.g., Jr., Sr., II, III)

Mother's Full Name: _____ **Maiden:** _____
Even if Deceased; First and Middle *Last Name Prior to First Marriage*

Next of Kin's Name: _____ **Relationship:** _____
First, Middle, and Last; Include Suffix (e.g., Jr., Sr., II, III)

Next of Kin's Address: _____
Street, City, State, and Zip

Phone: _____ **E-Mail:** _____