Indiana Anatomical Education Program
Administered by the Indiana University School of Medicine

CERTIFICATE OF BEQUEATHAL

It is my intention to make my body available to further the advancement of medical education. I therefore give my body to the Anatomical Education Program at the Indiana University School of Medicine, and direct that it or its appointees use my body and/or any portion thereof as it sees fit for medical, scientific or educational purposes. I hereby authorize the Anatomical Education Program to conduct blood and fluid testing. I understand that part of my body may be permanently preserved for teaching purposes. After use, my remains are to be cremated by the Indiana University School of Medicine.

I hereby direct the executor or administrator of my estate or other person who handles my affairs following my death to communicate with the appropriate persons associated with Indiana University regarding the handling of my body and its transportation to the Indiana University School of Medicine in Indianapolis, Indiana, immediately following my death. In order that my body be delivered to the Anatomical Education Program in its intact condition, I hereby direct that should medico-legal indication arise for an autopsy that no such post-mortem procedure be done prior to a conference with the Chair of the Board of the Anatomical Education Program.

By signing this form, I acknowledge that I have read and understand the Frequently Asked Questions document.

I further understand that signing this form does not guarantee automatic acceptance to the Program upon my death.

PLEASE PRINT LEGIBLY.

NAME: _____

ADDRESS: _____
(Street Address)

_____
(City) (State) (ZIP)

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

☐ SAVE CREMATED REMAINS: Please provide individual who should be contacted to receive cremains.

NAME: _____

ADDRESS: _____

TELEPHONE: _____

☐ NON-SAVE CREMATED REMAINS: The Anatomical Education Program will assume responsibility for disposition of remains in Crown Hill Cemetery, Indianapolis, Indiana.

DONOR'S SIGNATURE: _____ DATE: _____

WITNESS SIGNATURES:

(1) _____ DATE: _____

(2) _____ DATE: _____

DONATIONS TO THE ANATOMICAL EDUCATION PROGRAM

Indiana University accepts monetary donation to help support its teaching programs. Enclosed please find my gift of $_____ to the Anatomical Education Program. This gift should be used to further teaching and educational programs for medical, dental and allied health students in the State of Indiana.

THIS FORM MUST CONTAIN ORIGINAL SIGNATURES - <u>PHOTOCOPIES WILL NOT BE ACCEPTED</u>

Mail completed form to:
Anatomical Education Program
Medical Education and Research Building, HA2027
350 W. 14th St.
Indianapolis, Indiana 46202

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BIOGRAPHICAL INFORMATION

DONOR NAME: _____

DONOR'S PHONE or EMAIL: _____

SOCIAL SECURITY NUMBER: _____-_____-_____

RESIDENCE: _____

_____

COUNTY OF RESIDENCE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

EDUCATION LEVEL: _____

FATHER'S FULL NAME: _____

MOTHER'S FULL (MAIDEN) NAME: _____

MARITAL STATUS: _____

SPOUSE'S FULL MAIDEN NAME: _____

WERE YOU IN THE ARMED FORCES? Circle (YES) or (NO)

EMPLOYMENT:
Please provide information about the position you held for the longest length of time.

JOB TITLE: _____

INDUSTRY: _____

FAMILY INFORMATION

INFORMANT INFORMATION:
The informant is the individual who will provide information for the donor's death certificate. Typically, this is the closest next-of-kin.

INFORMANT NAME: _____ PHONE: _____

ADDRESS: _____

RELATIONSHIP TO DONOR: _____

SURVIVOR CONTACT INFORMATION:
Please provide name, address, and telephone number for family members.

SPOUSE: _____

_____

CHILDREN: _____
_____
_____
_____
_____

PARENTS: _____
_____

SIBLINGS: _____
_____
_____
_____
_____