INSTRUMENT OF ANATOMICAL GIFT

CONSENT AND AUTHORIZATION, DISPOSITION AND DECLARATION AS TO REMAINS FOR AN ANATOMICAL GIFT DONATION

I. CONSENT AND AUTHORIZATION

BEING OF THE AGE OF EIGHTEEN YEARS OR OVER AND OF SOUND MIND, I HEREBY OFFER AS AN UNRESTRICTED GIFT MY BODY, AFTER DEATH, FOR EDUCATION, RESEARCH AND THE ADVANCEMENT OF MEDICAL AND DENTAL SCIENCE OR THERAPY TO:

Harvard Medical School
ANATOMICAL GIFT PROGRAM
260 Longwood Avenue, Boston, Massachusetts 02115

I understand that upon my death, my decision to donate my body to HMS will become irrevocable, however I may revoke my offer to donate at any time before my death by informing Harvard Medical School ("HMS") in writing. I further understand that after my death this donation cannot be revoked by my next-of-kin without an order by a court of law. By signing this consent and authorization I intend for HMS to have the exclusive right to (i) control the use of my body for medical/dental education, research, science or therapy; and (ii) authorize the disposition of my body upon death.

The approval of my next-of-kin is not necessary to make this gift legally effective and enforceable, however, I do hereby direct my next-of-kin and any other person legally responsible for my remains to cooperate with HMS to carry out my wishes as set forth herein.

I understand that NO AUTOPSY should be performed and NO EMBALMING should be done upon my death, however after acceptance of the donation HMS may embalm and/or perform dissection for the purposes of education and/or research. I further understand that HMS reserves the right, at any time, to decline a particular anatomical gift and that acceptance of my body is contingent upon the decision of HMS at the time of my death. For this reason, I understand that I should have alternative arrangements for private interment or cremation if my offer to be a donor is declined. If my gift is accepted, a funeral director should be notified at once and requested to call HMS at 617.432.1735 for instructions about the transportation of my body to HMS. I UNDERSTAND THAT TRANSPORTATION OF MY BODY TO HMS MUST OCCUR WITHIN 24-HOURS OF THE TIME OF MY DEATH, UNLESS SPECIFIC EXEMPTION IS GRANTED BY HMS. FOR THIS REASON, I UNDERSTAND THAT HMS MUST BE NOTIFIED AT ONCE UPON MY DEATH AT 617.432.1735.

HMS will pay the funeral director described above a stipend for the costs of transportation and for obtaining necessary permits. I understand that my next-of-kin or executor will be responsible for any costs charged by the funeral director that exceed the HMS stipend.

I authorize any and all health care providers holding my health information at the time of my death to release my health information to HMS for the purpose of implementing my donation. In addition, I authorize HMS to use or disclose my health information as reasonably necessary to effectuate my donation (e.g., funeral personnel and others). I understand that once a health care provider or HMS discloses my health information to a recipient neither the health care provider nor HMS can guarantee that the recipient will not disclose my health information to a third party.

After acceptance of the gift of my body by HMS, HMS may in its sound judgment and sole discretion allow my body to be utilized by another medical or dental school, or another research, science or therapy institution for the purpose of advancing medical or dental education, research, science or therapy. At the conclusion of the use of my body by HMS (or by another, under HMS's permission), and except as otherwise provided below, HMS will be responsible for the disposition of my remains according to my direction below, and I hereby authorize HMS to arrange for cremation of my body. If HMS cannot carry out my instructions for any reason, I understand that HMS will arrange for my body to be cremated, and I hereby authorize HMS to arrange for the cremation.

II. DISPOSITION

I further direct that, after my body is no longer useful for the purposes stated above, HMS should coordinate the disposition of my remains as I have indicated below (indicate a ***single choice*** from the following options by placing a check mark within the brackets to the left of that option):

1. OPTIONS ARRANGED BY HMS, WITH CREMATION:

[ ] Cremate my remains and bury my cremains at HMS's expense at the Pine Hill Cemetery in Tewksbury, Massachusetts.

[ ] Cremate my remains, then contact and send my cremains at HMS's expense to my designee identified below:[1]

_____
(name)

_____
(street address or P.O. Box):

_____
(apt. number) (telephone number)

_____
(town) (state) (zip code)

_____
(relationship to donor)

[1] *If HMS is unable to locate and contact or does not receive a response from your designee within 60 days, your cremated remains will be buried at HMS's expense at the Pine Hill Cemetery in Tewksbury, Massachusetts.*

Leave this page BLANK if selection is made on page 2.

[ ] Cremate my remains and hold my cremains for pick-up by my designee at a site selected by HMS. (After my designee is notified by HMS that my cremains are available for pick-up, my designee should call the Anatomical Gift Program at 617.432.1735 to arrange for this.) HMS should contact the following designee regarding this matter:[2]

_____
(name)

_____
(street address or P.O. Box):

_____
(apt. number) (telephone number)

_____
(town) (state) (zip code)

_____
(relationship to donor)

2. OPTION WITHOUT CREMATION:

[ ] Release my remains without cremation, to the funeral director/home identified below, for disposition to be arranged by my estate at the expense of my estate. I understand that after use by HMS, my remains will not be in a condition suitable for viewing:[3]

Funeral Director _____

Address _____

Telephone Number _____

I understand that my remains or cremains will not include tissues that have been removed for medical research or education purposes.

I understand that this is a legal document being signed by me in accordance with the Massachusetts Anatomical Gift Act, M.G.L. ch. 113A §§ 1-25, and the Uniform Anatomical Gift Act. I understand that this consent and authorization will remain in effect unless I provide a written notice of revocation to HMS. The revocation will be effective immediately upon HMS's receipt of my written notice, except that the revocation will not have any effect on any action

[2] Cremated remains of a donor not claimed within 60 days following the notification, or the attempted notification, of the donor's designee will be buried at HMS's expense at the Pine Hill Cemetery in Tewksbury, Massachusetts.
[3] Remains of a donor not claimed within 60 days following the notification, or attempted notification, of the donor's designee will be cremated and buried at HMS's expense at the Pine Hill Cemetery in Tewksbury, Massachusetts.

taken by HMS in reliance on this authorization before it received my written notice of revocation. Having read this instrument in full and understanding its content and effect, and having had the opportunity to ask questions about this authorization, I hereby sign it and, knowingly and voluntarily consent to and authorize the actions described herein, in the presence of the witnesses whose signatures appear below:

Full Name of Donor (Please Print)	Signature of Donor
Mailing Address	Date of Birth
City, State Zip Code	Date
Telephone Number	

III. DECLARATION AS TO REMAINS

I, _____, do hereby make, constitute and designate Harvard Medical School's Anatomical Gift Program located at 260 Longwood Avenue, Boston, Massachusetts 02115, as the legally authorized party to control my bodily remains. Control over my remains includes authority to take any and all actions necessary to effectuate the donation of my body in furtherance of medical and dental education, research, science or therapy at the time of my death and the disposition of my remains at the time that my body may no longer be used in furtherance of medical and dental education, research, science or therapy. HMS's Anatomical Gift Program shall have the power and authority to authorize my cremation or my burial with or without cremation and to sign, seal, execute, acknowledge and deliver any and all documents or instruments of any kind, nature or description required by law or practice as it deems necessary and appropriate in order to effectuate and facilitate my donation and the disposition of my remains, including but not limited to, any and all statements, forms or authorizations concerning my donation or disposition and to do all other things necessary or appropriate to accept my donation and accomplish disposition of my remains.

WITNESS the execution of this Declaration this ____ day of _____ 20____.
(day) (month) (year)

DONOR:
Signature:_____

Name (Printed):_____

Date:_____

Please check to be certain that you have completed this page above with information in each of the (fourteen) underlined spaces provided.

WITNESSES' ATTESTATION

This consent and authorization to donate must be witnessed by two other parties.

If the donor has living next-of-kin at the time this form is signed and they can be contacted, HMS requests that the form be witnessed by two of the donor's next-of-kin as indicated below. HMS also requests that, to the extent possible, the witnesses are the donor's two highest priority next-of-kin.

IMPORTANT: Next-of-kin relationship is a legal definition. The order of next-of-kin priority is as follows: (1) current spouse; (2) an adult son or daughter; (3) either parent; (4) an adult brother or sister; (5) a guardian of the person of the decedent at the time of death.

We hereby sign our names as witnesses:

1)

_____
Signature of Witness

_____
Name of Witness (Please Print)

_____
Address

_____
City State Zip Code

_____
Telephone Number

_____
Relationship to Donor

2)

_____
Signature of Witness

_____
Name of Witness (Please Print)

_____
Address

_____
City State Zip Code

_____
Telephone Number

_____
Relationship to Donor

PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION
EXECUTOR OF DONOR'S ESTATE, IF ONE HAS BEEN APPOINTED

_____
Name (Please Print)

_____
Mailing Address

_____
City State Zip Code

_____
Telephone Number

Donor Data Sheet
Please Print

In addition to the information supplied on the INSTRUMENT OF ANATOMICAL GIFT, the following information is necessary for the completion of legal documents required at the time of death of a donor. Please complete the form below and return it with your completed INSTRUMENT.

Donor's Full Name (First, Middle, Last): _____

Donor's Legal Address (Street & Number; city or town; county; state; zip code): _____

Donor's Date of Birth: _____ Donor's Place of Birth: _____

Donor's Usual Occupation (Prior, if retired): _____ Now Retired?: Y/N

Race/Ethnicity: _____ Gender: M F (Circle One)

Donor's Education Level: _____

Donor's Marital Status (Never Married, Married, Widowed, Divorced): _____

Name of Last Spouse (include Maiden if applicable): _____

Donor's Social Security Number: (last 4 digits only): _____

Donor's Father (Full Name): _____ Father's Place of Birth: _____

Donor's Mother (Full Name): _____ Mother's Place of Birth: _____

Donor's Next of Kin (1st):

Full Name: _____

Address: _____

City/State/Zip Code: _____

Relationship to Donor: _____

Telephone: (___) _____

Donor's Next of Kin (2nd):

Full Name: _____

Address: _____

City/State/Zip Code: _____

Relationship to Donor: _____

Telephone: (___) _____

Donor's Veteran Information (most recent, if applicable):

If U.S. war veteran, specify war/conflicts: _____

Branch of military (most recent): _____ Rank, organization/outfit: _____

Date entered: _____ Date discharged: _____ Service number: _____