

DONATION OF BODY FOR MEDICAL/DENTAL SCIENCE

Be it known that I, (name) _____, now residing in _____, Texas, _____, being of sound mind, do hereby will and bequeath the remains of my body to the Anatomical Board of the State of Texas to be used in the advancement of medical and dental research and teaching.

It is my desire that my body be assigned to Baylor College of Dentistry, 3302 Gaston Ave., Dallas, TX 75246. However, to assure that maximum benefit is derived from this contribution, I authorize the Anatomical Board to transfer my body to other teaching or research institutions within the State of Texas if Baylor College of Dentistry does not have a need for my body at the time of my death. Moreover, I authorize the Anatomical Board of the State of Texas to transport the donated body out of the State of Texas in the event that the holding institution and the Executive Secretary have determined that an excess of bodies exist at that time in the State of Texas.

I understand that under a few circumstances, my body may not be accepted at the time of death, and in that event, my survivors will need to make other arrangements for the final disposition of my body. I understand that *if I have a contagious disease, if my body is damaged by violence at death, if an autopsy has been performed, if I commit suicide, if organs or parts have been removed for transplantation or otherwise, or if my body weight is over acceptable limits*, my body may not be acceptable to the Willed Body Program. If my body is accepted, I authorize the release of pertinent radiographs and information from my medical records to officials at the institution named above for the purpose of enhancement of the use of my body in medical/dental education research.

I hereby instruct those who will arrange for the disposition of my body to notify Baylor College of Dentistry at the following address and phone numbers so that appropriate arrangements can be made at the time of my death.

Baylor College of Dentistry
Department of Biomedical Sciences
3302 Gaston Avenue
Dallas, TX 75246
214-828-8260 (Weekdays 8:00 a.m.-5:00 p.m.)

If death occurs after 5:00 p.m., detailed instructions will be given in a recorded message on the following listed telephone number: 214-828-8270.

I understand that the receiving institution is obligated to pay only standard fees for the embalming and transportation of my body a distance of two hundred and fifty (250) miles or less from the institution. If my death should occur at a greater distance from the institution, I hereby instruct my representative to make the necessary transportation arrangements or authorize my body to be delivered to a closer institution approved by the Anatomical Board.

It is my understanding that the final disposition of my body shall be cremation, which may occur up to two years after the institution receives my body.

I do not wish to have my ash remains returned. **I wish** to have my ash remains returned.

If the family desires that the ash remains be returned to them, they should be returned to the following address. Please update this address as necessary in the future.

Name _____ Relationship to the deceased _____

Address: _____

Phone numbers: (Home) _____; (Cell) _____

I hereby relinquish all rights and claims regarding the body and direct that in accepting and using this body for scientific purposes, and in the final disposition of the body, neither the Anatomical Board of the State of Texas nor the receiving institution shall incur any liability, and no claim shall arise against that institution in any manner. I understand that complaints or inquiries regarding a willed or donated body should be directed to the Executive Secretary of the Anatomical Board of Texas. The name and address of this individual may be obtained from Baylor College of Dentistry.

WITNESS MY Hand this _____ day of _____, _____.

Signed: _____

Printed Name: _____

Address: _____

Signatures and addresses of two (2) witnesses:

I, the undersigned witness, hereby certify that I am over 21 years of age on this date and that I have witnessed the above signature.

Witness: _____

Witness: _____

Printed Name: _____

Printed name: _____

Address: _____

Address: _____

The following personal information about the donor will facilitate recording of the death certificate.

Social Security # _____

Date of birth: _____

Place of birth: _____

Citizen of what country? _____

Occupation when working: _____

Father's name: _____

Mother's maiden name: _____

Spouse's name (maiden name): _____

Branch of military service: _____

Serial number: _____

Name and address of personal physician: _____
