

## DONATION OF FAMILY MEMBER'S BODY FOR MEDICAL/DENTAL SCIENCE

### To the Anatomical Board of the State of Texas:

In accordance with the desires of (name of family member) \_\_\_\_\_, to whom I am related as (relationship) \_\_\_\_\_, I authorize the Anatomical Board of the State of Texas to use the body of my family member for medical and dental research and teaching.

It is my desire that my family member's 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 his/her body to other teaching or research institutions within the State of Texas if Baylor College of Dentistry does not have a need for his/her body at the time of 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 Secretary-Treasurer have determined that an excess of bodies exist at that time in the State of Texas.

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

I understand that Baylor College of Dentistry should be notified of my family member's death at the following address and phone numbers so that appropriate arrangements can be made.

**Baylor College of Dentistry  
Department of Biomedical Sciences  
3302 Gaston Avenue  
Dallas, TX 75246  
214-828-8270 (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: 214-828-8276.**

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

It is my understanding that the final disposition of my family member's body shall be cremation, which may occur up to two years after the institution receives his/her body.

**I do not** wish to have the ash remains returned.  **I wish** to have the 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 address as necessary.)**

Name \_\_\_\_\_ Relationship to the deceased \_\_\_\_\_

Address: \_\_\_\_\_

Phone numbers: (Home) \_\_\_\_\_; (Cell) \_\_\_\_\_

I hereby relinquish all rights and claims regarding my family member's 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 Secretary-Treasurer 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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The following personal information about the deceased 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: \_\_\_\_\_

\_\_\_\_\_