TEXAS A&M UNIVERSITY
College of Dentistry

Texas A&M College of Dentistry Anatomical Gift Program | Department of Biomedical Sciences
3302 Gaston Avenue | Dallas, TX 75246
(214) 828-8276

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

Family Member's full name: _____ Relationship: _____

In accordance with the desires of my family member, I authorize the Texas Funeral Service Commission to use his/her body for medical and dental research and teaching. It is my desire that my family member's body be assigned to Texas A&M 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 the College of Dentistry does not have a need for his/her body at the time of death. Moreover, I authorize the Texas Funeral Service Commission to transport the donated body out of the State of Texas in the event that the holding institution and the Anatomical Committee have determined that an excess of bodies exist at that time in the State of Texas. I understand that the **Anatomical Gift Program at the school should be notified immediately (214-828-8276) of my family member's death**, so that appropriate arrangements can be made. Staff will schedule transport for my family member's body. 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, and the Willed Body Program is not responsible for any costs associated with other arrangements. I understand that if he/she has a contagious disease, if the body is damaged by violence at death, if an autopsy is performed, if he/she commits suicide, if the body is embalmed, if organs or parts are 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 and research. I understand that the school is obligated to pay only standard fees for the embalming and transportation of my family member's body a distance of 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 and payment arrangements or locate a closer institution approved by the Texas Funeral Service Commission where the body can be delivered.

I hereby relinquish all rights and claims regarding my family member's body and direct that in accepting and using his/her body for scientific purposes, and in the final disposition of the body, neither the Texas Funeral Service Commission 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 Texas Funeral Service Commission. The name and address of this individual may be obtained from the college and is listed in the Texas State Telephone directory.

Date: _____ Signature of Relative or agent: _____

Printed name of Relative or agent: _____
Relative or agent's address: _____
Relative or agent's phone: _____

Signature of witness: _____
Printed name of witness: _____
Witness' address: _____
Witness' phone: _____

Signature of second witness: _____
Printed name of second witness: _____
Second witness' address: _____
Second witness' phone: _____

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Donor's Personal Data (please print or type)

This information will facilitate recording of the death certificate

Date: _____

Donor's Full Name: _____

Donor's Address: _____

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

Donor's Social Security Number: _____ Donor's Gender: _____

Married: _____ Divorced: _____ Never Married: _____ Widowed: _____ Widowed Spouse's Name: _____

Father's Full Name: _____ Mother's Full Name: _____

Donor's Occupation when working (**do not write Retired**): _____ Type of Business: _____

Veteran (Yes/No): _____ Branch of Service: _____ Texas Peace Officer (Yes/No): _____

Diagnosed with contagious disease (Yes/No):_____ If yes, list here: _____

List organs removed by surgery: _____

Father's Full Name: _____ Mother's Full Name: _____

Education (optional)
_____ 8th Grade or Less
_____ 9th-12th Grade (no Diploma)
_____ High School graduate/GED
_____ Some College
_____ Associate's degree
_____ Bachelor's Degree
_____ Master's Degree
_____ Doctorate/Professional

Hispanic Origin (optional)
_____ No (Not Hispanic/Latino)
_____ Yes (Mexican, Mexican American, Chicano)
_____ Yes (Puerto Rican)
_____ Yes (Cuban)
_____ Yes (Other Hispanic/Latino)

Race
Check one or more races to indicate what you consider yourself to be:
_____ White
_____ Black/African-American
_____ American Indian (Specify Tribe)
_____
_____ Asian (specify country)
_____
_____ Native Hawaiian
_____ Native Alaskan

Contact information for agent or nearest relative:

Relative's Full Name: _____

Relative's Address: _____

Relative's Phone Number: _____ Relationship to Donor: _____

Cremation:

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 Texas A&M College of Dentistry receives his/her body.

_____ I **do not** wish to have the ash remains returned to the family.

_____ I wish to have the ash remains returned to the person listed below:

Recipient's Full Name: _____ Relationship to Donor: _____

Recipient's Address: _____

Recipient's Phone Number: _____ Recipient's Signature: _____