

Anatomical Gift Form

**Willed Body Program
WSU Health Sciences Spokane
Elson S. Floyd College of Medicine, PBS 12
412 E. Spokane Falls Blvd.
Spokane, WA 99202-2131**

I agree that, upon my death, I wish my body to be offered to the **Washington State University Willed Body Program**, to be preserved and used in such a manner as the University deems desirable for educational purposes.

I agree that the University may loan my body or any of its parts to other institutions for purposes of medical teaching. Upon completion of use (four years maximum), my body shall be cremated and the cremated remains will be returned to the family or interred at the Greenwood Cemetery in Palouse, Washington, as indicated on the Final Interment Form.

I agree that the University may keep any of my body parts indefinitely for continuing educational purposes.

I agree that the University reserves the right to decline my body donation for any reason. The acceptance or declining of a body donation is made at the time of death. I am aware that alternate arrangements should be made in the event my body donation is declined.

I agree to inform my family and physician of my decision to donate my body to the Washington State University Willed Body Program.

AUTHORIZATION

I wish to give my body to the Washington State University Willed Body Program immediately after my death to be preserved and used by the University for medical teaching and research.

Print Full Name _____ Date _____

Donor Signature _____

REQUIRED: Two witness signatures (Can be a family member or a friend)

Witness 1: _____ Date _____

Witness 2: _____ Date _____

Complete this form, sign, date, and return the **original copy** to Washington State University at the address above. Before mailing this form make copies for your records, your family, and your physician.

Final Interment Form

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Donor Name _____

Select one of the two options below for the final disposition of the cremated remains by checking the appropriate box. If you select Option 2, please provide the information requested for the legal next of kin.

Option 1

- **Bury my cremated remains at the Washington State University Willed Body Program burial site at Greenwood Cemetery, Palouse, Washington.** There is no cost to the donor's estate for Option 1.
- This is a Willed Body Program community gravesite marked by a plaque with the inscription "In dedication to those who have donated their remains for the advancement of medical science and education."
- If you wish to have your name, date of birth and date of death engraved in the memorial stone, contact Mark Kramer at Kramer's Funeral Home in Palouse, Washington, (509-878-1221) to make the arrangements. This engraving service is provided at the expense of the family.

Option 2

- **Return my cremated remains to the residence of my legal next of kin for private burial by the family** (unless instructed differently by your legal next of kin, i.e. spouse, son, daughter, etc.) after your death. Your family will be notified by mail or phone before the cremated remains are sent. The cost of transporting your cremated remains is paid for by the Washington State University Willed Body Program if the destination is within the United States or Canada.
- The final resting place of the cremated remains is determined and paid for by the donor's family or estate.

Print Name of Legal Next of Kin _____

Sign Name of Legal Next of Kin _____

Phone number _____

Address _____

City _____ State _____ Zip code _____

Donor Signature _____ Date _____

Personal and Contact Information Form

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Full name of donor (print) _____

Date _____ Phone number _____

Email address _____

Current address _____

City _____ State _____ Zip _____

County of residence _____ Within city limits: Yes No

Length of time at current residence _____ U.S. citizen: Yes No

Date of birth _____ Male Female
Month Day Year

Place of birth _____
City County State

Social Security Number _____ U.S. Veteran: Yes No

Marital status: Single Married Widowed Divorced

Surviving spouse's name (wife's maiden name) _____
First Middle Last

Primary occupation _____

Type of business/industry _____

Highest level of education/degree _____

Ethnicity: White Black Asian Hispanic Native American Other _____

Donor's father's name _____
First Middle Last

Donor's mother's maiden name _____
First Middle Last

Next of Kin/Executor of Estate Contact Information

Name _____

Relationship to donor _____

Address _____

City _____ State _____ Zip _____

Phone number(s) _____

Email address _____

Alternate Contact Information

Name _____

Relationship to donor _____

Address _____

City _____ State _____ Zip _____

Phone number(s) _____

Email address _____

- Please mail all original forms to:
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Fax: 509-368-6987

- Make photocopies for your records, your family, and your physician
- If you have additional questions, please call 509-368-6600

Medical History Form

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Donor's name _____

Date of birth _____ Height _____ Weight _____

Current health problems: _____

For the following, please list the month and year of any organ removal, transplants, pacemaker, deformities, amputations, etc.

Past health problems: _____

Surgical history: _____

Do you have a pacemaker? Yes _____ No _____

Today's date _____