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

Willed Body Program

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

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

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

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

  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

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

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 ________________________________