Anatomical Gift Form

Willed Body Program
WSU Health Sciences | Elson S. Floyd College of Medicine
412 E. Spokane Falls Blvd., PBS 12
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 Disposition 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 ________________________
Full name of donor (print) _____________________________________________

Date ____________________  Phone number ____________________________

Email ____________________________________________________________

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

Place of birth ___________________________________________

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

Marital status:  Single  Married  Widowed  Divorced

Surviving spouse’s name (wife’s maiden name) ___________________________________________

Primary occupation ____________________________________________________________

Type of business/industry _________________________________________________________

Highest level of education/degree __________________________________________________

Ethnicity:  White  Black  Asian  Hispanic  Native American  Other ______________

Donor’s father’s name ____________________________________________________________

Donor’s mother’s maiden name ____________________________________________________
Next of Kin/Executor of Estate Contact Information

Name ____________________________________________________________

Relationship to donor _____________________________________________

Address _________________________________________________________

City ___________________________ State _______ Zip ____________

Phone number(s) _________________________________________________

Email __________________________________________________________

Alternate Contact Information

Name ____________________________________________________________

Relationship to donor _____________________________________________

Address _________________________________________________________

City ___________________________ State _______ Zip ____________

Phone number(s) _________________________________________________

Email __________________________________________________________

➢ Please mail all original forms to:

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

➢ 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, amputations, etc.

Past health problems _______________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Surgical history ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have a pacemaker?  Yes  No

Today’s date ________________________________