



## ANATOMICAL GIFT FORM

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

# FINAL DISPOSITION FORM

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 \_\_\_\_\_

# MEDICAL HISTORY FORM

Donor's Name

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Date Of Birth

Height

Weight

---

Today's Date

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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

Have You Had A Hysterectomy?  Yes  No

Do You Have A Pacemaker?  Yes  No

# PERSONAL AND CONTACT INFORMATION FORM

Full Name Of Donor (Print)

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Date

Phone Number

---

Email

---

Current Address

---

City

State

Zip Code

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County Of Residence

Within City Limits:  Yes  No

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Length Of Time At Current Residence

US Citizen:  Yes  No

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Date Of Birth (MM/DD/YYYY)

Male  Female

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Place Of Birth (City, State, Country)

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U.s. Veteran  Yes  No

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Marital Status:  Single  Married  Widowed  Divorced

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Surviving Spouse's Maiden Name (Frist, Middle, Last)

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Primary Occupation Prior to Retirement

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Type Of Business/Industry

---

Highest Level Of Education/Degree

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Ethnicity:  White  Black  Asian

Hispanic  Native American  Other

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Donor's Father's Name (First, Middle, Last)

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Donor's Mother's Maiden Name (First, Middle, Last)

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**Next of Kin/Executor of Estate Contact Information**

Name \_\_\_\_\_

Relationship To Donor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number(S) \_\_\_\_\_

Email \_\_\_\_\_

**Alternate Contact Information**

Name \_\_\_\_\_

Relationship To Donor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number(S) \_\_\_\_\_

Email \_\_\_\_\_

**Print completed form and mail to:**

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

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