



Anatomical Gift Donation Form

Please complete this form in its entirety, all information is required by the State of Hawaii Department of Health. All information is kept confidential. Please Print Legibly or Type. All fields are **REQUIRED** unless otherwise marked.

Please list your full legal name as indicated on your Social Security Card.

1. FIRST NAME		1a. MIDDLE NAME (check <input type="checkbox"/> if None)		1b. LAST NAME	
2. Other Legal Names Used			3. Last Name on Current Birth Certificate		
4. Sex <input type="checkbox"/> Male (M) <input type="checkbox"/> Female (F) <input type="checkbox"/> Transgender <input type="checkbox"/> M to F or <input type="checkbox"/> F to M		5. Social Security Number		6. Age	7. Date of Birth
8. State of Birth or Country (list country if not born in USA)		9. # of Yrs in Hawaii	10. # of Yrs in USA	11. Citizen of What Country? <input type="checkbox"/> USA <input type="checkbox"/> _____	
12. Island of Residence <input type="checkbox"/> Big Island <input type="checkbox"/> Kauai <input type="checkbox"/> Maui <input type="checkbox"/> Molokai <input type="checkbox"/> Oahu <input type="checkbox"/> Other _____					
13. Residential Address			13a. City or Town, State		13b. Zip Code
14. Mailing Address (check <input type="checkbox"/> if same as above)			14a. City or Town, State		14b. Zip Code
15. Email Address			16. Home Phone		16a. Cell Phone
17. Have you served in the U.S. Armed Forces (Active duty only): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list branches and dates below: Branch(es): _____ Rank: _____ Dates: _____					
18. Marital Status (Please check one) <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Married but Separated					
19. Your Education (highest grade completed): <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th -12 th grade, no diploma <input type="checkbox"/> High School Graduate or GED Completed <input type="checkbox"/> Some College credit but no degree <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate JD/MD/PhD/EdD/etc					
20. Ethnicity/Race			20a. Of Hispanic Origin? <input type="checkbox"/> No <input type="checkbox"/> Yes		21. Religious Affiliation (Optional)
22. Main Occupation (prior to retirement)			22a. Kind of Business or Industry		22b. Retired? <input type="checkbox"/> No <input type="checkbox"/> Yes
23. Your Father's Full Name	23a. FIRST NAME		23b. MIDDLE NAME (check <input type="checkbox"/> if None)		23c. LAST NAME
24. Your Mother's Full Name	24a. FIRST NAME		24b. MIDDLE NAME (check <input type="checkbox"/> if None)		24c. MAIDEN NAME (Prior to Marriage)
Father Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes			Mother Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes		



Anatomical Gift Donation Form- Page 2 of 4

25. SPOUSE INFORMATION – If you are divorced or widowed, you may leave this blank

25a. FIRST NAME	25b. MIDDLE NAME (check <input type="checkbox"/> if None)	25c. LAST NAME (Prior to Marriage)
25d. Mailing Address		25e. City or Town, State
		25f. Zip Code
25g. Email Address	25h. Home Phone	25i. Cell Phone

YOUR BRIEF MEDICAL HISTORY AND INFORMATION

26. Your present state of health: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent		<input type="checkbox"/> Enrolled in Hospice? Please list name of Hospice below: _____
27. Please list illnesses, operations and accidents: _____ _____ _____		
28. Have you had any organs removed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list below: _____ _____		
29. Do you currently have any of the following? Please check the appropriate box(es): <input type="checkbox"/> Active Tuberculosis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV <input type="checkbox"/> Creutzfeldt-Jakob <input type="checkbox"/> COVID-19		
30. Weight	31. Height	32. Primary Care Physician's Name & Phone Number

33. DO YOU WISH TO HAVE YOUR CREMAINS RETURNED?

No, please scatter my cremains at sea (skip to #34) Yes, please return my cremains to:

33a. FIRST NAME	33b. MIDDLE NAME (check <input type="checkbox"/> if None)	33c. LAST NAME
33d. Mailing Address		33e. City or Town, State
		33f. Zip Code
33g. Email Address	33h. Phone Number(s)	33i. Relationship



Anatomical Gift Donation Form – Page 3 of 4

34. DESIGNATED LEGAL NEXT-OF-KIN (NOK)

Please make sure your Next-of-Kin is aware of your wishes.

34a. NOK FIRST NAME	34b. NOK MIDDLE NAME (check <input type="checkbox"/> if None)	34c. NOK LAST NAME
34d. NOK Mailing Address		34e. City or Town, State
		34f. Zip Code
34g. NOK Email Address	34h. Phone Number(s)	34i. Relationship

35. IMPORTANT SURVIVOR CONTACT INFORMATION

Please list living relatives or responsible persons, in order of priority below. This information is important in case we are unable to reach your designated Next-of-Kin. Please notify those listed of your intent to donate.

(Adult Children, Parents, Adult Siblings, Guardian, Agent or Attorney)

NAME	ADDRESS & PHONE NUMBER(S)	RELATIONSHIP

*If you have more living survivors than the spaces provided, please attach an additional sheet.

36. PERMANENT DONATION

On occasion, an organ or body part may be exceptionally useful for teaching purposes and it is desirable to preserve and retain it permanently for future education. Would you like to make your body donation permanent? The remainder of your body will be cremated and scattered at sea, or returned, based on your request. We highly recommend choosing 'Yes' as it allows our program more flexibility in placing you in the teaching/research program best for you.

No, I do not.

Yes, I would like to make a permanent donation.



Anatomical Gift Donation Form – Page 4 of 4

I, _____, am at least 18 years of age, and wish to donate my body immediately following death, to the University of Hawaii at Manoa, John A. Burns School of Medicine (JABSOM), 651 Ilalo Street, Honolulu, Hawaii 96813. Said University shall use my body for teaching, scientific research, training, or as the University shall in its sole discretion deem advisable. I understand that, for the purposes of education or research, the Willed Body Program reserves the right to create and share/distribute photographic, video, extended reality renderings, or other multimedia of my donation in ways that are de-identified and with the respect for my dignity. The remainder of my body will be cremated and scattered at sea, or returned to whom I designated, based on my request.

I understand that the JABSOM Willed Body Program may not be able to accept my body at the time of death, in which case my next-of-kin/agent will make other arrangements for final disposition at their expense or the expense of my estate.

I want to donate for the following reason(s): _____

ALL SIGNATURES & ADDRESSES ARE REQUIRED FOR DONATION TO BE VALID

Donor/Agent's Signature

DONOR/AGENT'S SIGNATURE	DATE
DONOR'S NAME – PRINTED	If signing for Donor, what is your Relationship?
Residential Address, City or Town, State, Zip Code	Phone Number(s)
Mailing Address, City or Town, State, Zip Code (check <input type="checkbox"/> if same as above)	Email Address

Witness Signatures (Two Witness signatures are required in addition to the Donor/Agent's signature)

Witness	SIGNATURE	PRINTED NAME	DATE
Witness	SIGNATURE	PRINTED NAME	DATE

Thank you for your consideration. If you have any questions, please contact our office at 808-692-1445 between the hours of 8:00am and 4:30pm, HST, Monday through Friday, or by email at wbdonor@hawaii.edu.

FORM WITH ORIGINAL SIGNATURES REQUIRED. COPY NOT ACCEPTED.