University of Hawaii at Manoa, John A. Burns School of Medicine
Willed Body Program
(808) 692-1445 wbdonor@hawaii.edu

Anatomical Gift Update Form- Page 1 of 2

Please complete this form in its entirety so that we may have the most current information in your donor file. *All information is kept confidential*. Thank you for your time. Completion of this form is **REQUIRED** to remain enrolled with the Willed Body Program. Failure to complete this form may result in our inability to accept your donation at the time of your death.

If you wish to **CANCEL** your donation please check here ☐ and complete **Section 1 & Section 20 only**.

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

1. FIRST NAME	1a. MIDDLE NAME (or ☐ if None)	1b. LAST NAME

2. OTHER **LEGAL** NAMES USED	3. CITIZEN OF WHAT COUNTRY? ☐ USA or ☐ ____________________

4. CURRENT MARITAL STATUS (Please check one)
☐ Never Married ☐ Married ☐ Divorced ☐ Widow(er) ☐ Married but Separated

5. YOUR EDUCATION (highest grade completed): ☐ 8th grade or less ☐ 9th-12th grade, no diploma
☐ High School Graduate or GED Completed ☐ Some College credit but no degree ☐ Associate Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate – JD/MD/PhD/EdD/etc

6. YOUR MAIN OCCUPATION (**prior to retirement**)	6a. KIND OF BUSINESS OR INDUSTRY?	6b. RETIRED? ☐ No ☐ Yes

7. SPOUSE'S NAME

7a. SPOUSE'S FIRST NAME	7b. SPOUSE's MIDDLE NAME (or ☐ if None)	7c. SPOUSE'S LAST NAME (**Prior to marriage)**

8. YOUR PRESENT STATE OF HEALTH: ☐ Enrolled in Hospice? Please list name of Hospice below:
☐ Poor ☐ Fair ☐ Good ☐ Excellent ______________________________

9. Please list any illnesses, operations and accidents since you last joined or last updated:
____
____

10. Have you had any organs removed? ☐ No ☐ Yes If yes, please list below:
____
____

11. Do you currently have any of the following? Please check the appropriate box(es):
☐ Active Tuberculosis ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Creutzfeldt-Jakob ☐ COVID-19

12. Weight	13. Height	14. Religious Affiliation (Optional)

15. Primary Care Physician's Name & Phone Number

Return form to: University of Hawaii at Manoa, JABSOM
Department of Anatomy, Willed Body
Program 651 Ilalo Street, BSB 119
Honolulu, HI 96813

*NOTE: This is a double-sided form

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Anatomical Gift Update Form- Page 2 of 2

16. DO YOU WISH TO HAVE YOUR CREMAINS RETURNED?

☐ **NO**, please scatter my cremains at sea (skip to #17) ☐ **YES**, please return my cremains to:

16a. FIRST NAME	16b. MIDDLE NAME (check ☐ if None)	16c. LAST NAME

16d. MAILING ADDRESS	16e. CITY, STATE	16f. ZIP CODE
16g. EMAIL ADDRESS	16h. PHONE NUMBER	16i. RELATIONSHIP

17. DESIGNATED LEGAL NEXT-OF-KIN (NOK) – Please make sure your Next-of-Kin is aware of your wishes.

17a. NOK FIRST NAME	17b. NOK MIDDLE NAME (check ☐ if None)	17c. NOK LAST NAME

17d. NOK MAILING ADDRESS	17e. CITY, STATE	17f. ZIP CODE
17g. NOK EMAIL ADDRESS	17h. PHONE NUMBER(S)	17i. RELATIONSHIP

18. IMPORTANT SURVIVOR CONTACT INFORMATION

Please list living relatives or responsible persons **(Adult Children, Parents, Adult Siblings, Guardian, Agent or Attorney)**, in order of priority below. This information is important in the event we are unable to reach your designated Next-of-Kin. Please notify those listed of your intent to donate.

NAME	*ADDRESS & PHONE NUMBER(S)*	*RELATIONSHIP*

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

19. DO YOU NEED A NEW DONOR ID CARD? ☐ Yes ☐ No

PLEASE NOTE: Due to the ongoing COVID-19 situation, our ways of teaching have changed greatly. In order to accommodate the education of our students, while keeping them safe, much of our teaching has gone virtual. By signing below, I acknowledge and 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 respect for my dignity. Further note that, if you do not cancel your donation, we will follow your previous designation concerning participation in permanent donation.

20. *PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE, DATE & CONTACT INFORMATION*

DONOR SIGNATURE	**DATE**

RESIDENTIAL ADDRESS	CITY, STATE	ZIP CODE
MAILING ADDRESS (check ☐ if same as above)	CITY, STATE	ZIP CODE

CONTACT PHONE NUMBER(S)	EMAIL ADDRESS

***NOTE: This is a double-sided form**