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

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 ☐ if None)	1b. LAST NAME	
2. Other **Legal** Names Used		3. Last Name on Current Birth Certificate	
4. Sex ☐ Male (M) ☐ Female (F) ☐ Transgender ☐ M to F or ☐ 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? ☐ USA ☐ _____
12. Island of Residence ☐ Big Island ☐ Kauai ☐ Maui ☐ Molokai ☐ Oahu ☐ Other _____			
13. Residential Address	13a. City or Town, State	13b. Zip Code	
14. Mailing Address (check ☐ 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): ☐ No ☐ Yes If yes, list branches and dates below: Branch(es): _____ Rank: _____ Dates: _____			
18. Marital Status (Please check one) ☐ Never Married ☐ Married ☐ Divorced ☐ Widow(er) ☐ Married but Separated			
19. 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			
20. Ethnicity/Race	20a. Of Hispanic Origin? ☐ No ☐ Yes	21. Religious Affiliation (Optional)	
22. Main Occupation (**prior to retirement**)	22a. Kind of Business or Industry	22b. Retired? ☐ No ☐ Yes	
23. Your Father's Full Name	23a. FIRST NAME	23b. MIDDLE NAME (check ☐ if None)	23c. LAST NAME
24. Your Mother's Full Name	24a. FIRST NAME	24b. MIDDLE NAME (check ☐ if None)	24c. MAIDEN NAME (Prior to Marriage)
Father Deceased? ☐ No ☐ Yes		Mother Deceased? ☐ No ☐ Yes	

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

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

25a. FIRST NAME	25b. MIDDLE NAME (check ☐ 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: ☐ Enrolled in Hospice? Please list name of Hospice below:

☐ Poor ☐ Fair ☐ Good ☐ Excellent _____

27. Please list illnesses, operations and accidents: _____

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

29. 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

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 ☐ 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

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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 ☐ 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.

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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 ☐ 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.