



## 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 <input type="checkbox"/> if None)	1b. LAST NAME
2. OTHER <b>LEGAL</b> NAMES USED		3. CITIZEN OF WHAT COUNTRY? <input type="checkbox"/> USA or <input type="checkbox"/> _____	
4. CURRENT 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			
5. YOUR EDUCATION (highest grade completed): <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> 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			
6. YOUR MAIN OCCUPATION ( <b>prior to retirement</b> )		6a. KIND OF BUSINESS OR INDUSTRY?	6b. RETIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>7. SPOUSE'S NAME</b>			
7a. SPOUSE'S FIRST NAME	7b. SPOUSE's MIDDLE NAME (or <input type="checkbox"/> if None)	7c. SPOUSE'S LAST NAME ( <b>Prior to marriage</b> )	
8. YOUR PRESENT STATE OF HEALTH: <input type="checkbox"/> Enrolled in Hospice? Please list name of Hospice below: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent    _____			
9. Please list any illnesses, operations and accidents since you last joined or last updated: _____ _____			
10. Have you had any organs removed? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, please list below: _____ _____			
11. 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			
12. Weight	13. Height		14. Religious Affiliation (Optional)
15. Primary Care Physician's Name & Phone Number			



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:

Form with fields: 16a. FIRST NAME, 16b. MIDDLE NAME, 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.

Form with fields: 17a. NOK FIRST NAME, 17b. NOK MIDDLE NAME, 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.

Table with 3 columns: 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

Form with fields: DONOR SIGNATURE, DATE, RESIDENTIAL ADDRESS, CITY, STATE, ZIP CODE, MAILING ADDRESS, CONTACT PHONE NUMBER(S), EMAIL ADDRESS