DENTISTRY
TEXAS A&M UNIVERSITY
Anatomical Gift Program | Department of Biomedical Sciences
3302 Gaston Avenue | Dallas, TX 75246
214.828.8276 | Fax 214.874.4538

DONATION OF BODY FOR MEDICAL/DENTAL SCIENCE

(PLEASE CIRCLE ONE) Dr. Mr. Mrs. Ms.

Be it known that I, _____,
FIRST NAME MIDDLE NAME LAST NAME (MAIDEN NAME)

being of sound mind, do hereby will and bequeath the remains of my body to the Anatomical Board of the State of Texas to be used in the advancement of medical and dental research and teaching. It is my desire that my body be assigned to Texas A&M School of Dentistry, 3302 Gaston Ave., Dallas, TX 75246.

I hereby instruct those who will arrange for the disposition of my body to **immediately notify the Anatomical Gift Program at Texas A&M School of Dentistry, Dallas, Texas, 214-828-8276,** at the time of my death, so that appropriate arrangements can be made with their staff, who will arrange transportation.
I authorize the Anatomical Board of the State of Texas to transport the donated body out of the State of Texas in the event that the holding institution and the Secretary-Treasurer have determined that an excess of bodies exist at that time in the State of Texas.
I understand that the receiving institution is obligated to pay only standard fees for the embalming and transportation of my body a distance of 250 miles or less from the institution. If my death should occur at a greater distance from the institution, ***I hereby instruct my representative to pay for the transportation in excess of 250 miles*** or to locate a closer institution approved by the Anatomical Board where my body can be delivered.

I understand that under a few circumstances, my body may not be accepted at the time of death. In that event, my survivors will need to make other arrangements for the final disposition of my body, and the Anatomical Gift Program is not responsible for any costs associated with other arrangements. I understand that ***if I have a contagious disease (e.g. HIV, Hepatitis, TB), if my body is damaged by violence at death, if an autopsy has been performed, if I commit suicide, if my body has been embalmed, if organs or parts have been removed for transplantation or otherwise, or if my body weight is over acceptable limits,*** my body may not be acceptable to the Anatomical Gift Program. If my body is accepted, I authorize the release of pertinent radiographs and information from my medical records to officials at the institution named above for the purpose of enhancement of the use of my body in medical/dental education and research.

I hereby relinquish all rights and claims regarding my body and direct that in accepting and using my body for scientific purposes, and in the final disposition of my body, neither the Anatomical Board of the State of Texas nor the receiving institution shall incur any liability, and no claim shall arise against that institution in any manner. I understand that complaints or inquiries regarding a willed or donated body should be directed to the Secretary-Treasurer of the Anatomical Board of Texas. The name and address of this individual may be obtained from Texas A&M College of Dentistry and is listed in the Texas State Telephone directory.

Date: _____ Donor's signature: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

I, the undersigned witness, hereby certify that I am over 21 years of age on this date and that I have witnessed the above signature. (Signatures and addresses of two (2) witnesses required.)

Witness' signature PRINT	Witness' signature PRINT
Address	Address
City, state, zip	City, state, zip
Phone	Phone

PERSONAL DATA

PLEASE PRINT OR TYPE

The following personal information will facilitate recording of the death certificate.

Date: _____ Social security #: _____

Name: _____
FIRST MIDDLE LAST (MAIDEN)

Address: _____
NUMBER AND STREET CITY STATE ZIP COUNTY

Date of birth: _____ Place of birth: _____

Gender: ☐Male ☐Female Marital status: ☐Married ☐Never married ☐Divorced ☐Widowed

Spouse's name: _____
FIRST MIDDLE LAST (MAIDEN)

Father's name: _____
FIRST MIDDLE LAST

Mother's name: _____
FIRST MIDDLE LAST (MAIDEN)

Occupation when working (do not use retired): _____ Type of business: _____

U.S. Veteran: ☐Yes ☐No Branch of military service: _____ Serial #: _____

Peace officer for the State of Texas: ☐Yes ☐No Height: _____ Weight: _____

Have you ever been diagnosed with a contagious disease? ☐Yes ☐No If yes, which one(s)? _____

Education: (Optional)
Check highest degree or level of school completed

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate's degree (AA, AS)
- ☐ Bachelor's degree (BA, AB, BS)
- ☐ Master's degree (MA, MS, MEng, Med,MSW, MBA)
- ☐ Doctorate (PhD, EdD) or professional degree (MD, DDS, DVM, LLB, JD)

Of Hispanic Origin? (Optional)
Check the one that best describes you.
Check "No" if you are not Spanish/Hispanic/Latino

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)_____

Ethnicity: (Optional)
Check one or more races to indicate what you consider yourself to be

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
  (Specify name of tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify)_____
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander (Specify)_____
- ☐ Other (Specify)_____

Contact information for nearest relative:

Name: _____ Relationship: _____

Address: _____ City, state, zip _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Cremation:

It is my understanding that the final disposition of my body shall be cremation, which may occur up to two years after Texas A&M College of Dentistry receives my body.

☐ **I do not** wish to have my ash remains returned to my family.

☐ **I wish** to have my ash remains returned to the person listed below. I understand I will need to keep their contact information updated.

Name: _____ Relationship to donor: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Donor's signature: _____