



# CASE WESTERN RESERVE UNIVERSITY

## School of Medicine

FORM 1

Anatomical Gift  
*Of*

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Print Name of Living Donor

In the hope that I may help others upon my death, I hereby give my entire body to the School of Medicine, Case Western Reserve University, subject to terms specified herein, for education or any other purpose authorized by law.

I understand and agree as follows: that the School of Medicine may refuse to accept my body at the time of death; that if the School of Medicine accepts my body, it may not be used by my family in a funeral service, that when the School of Medicine is finished with my body they will cause it to be cremated; and, that my remains will be commingled with other ashes and interred at Riverside Cemetery, located at 3607 Pearl Road Cleveland, Ohio 44109, unless I have provided written directions for the private deposition of my remains, in which case the school of Medicine will make a reasonable attempt to comply therewith.

Signed by the donor and the following two witnesses in the presence of of each other on this \_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_:

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Signature of Witness	Print name of Witness	Signature of Donor
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Signature of Witness	Print name of Witness	Signature of Donor
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This is a legal document under the Uniform Anatomical Gift Act or similar laws.  
The School of Medicine Department of Anatomy must be notified immediately after your death so that the action necessary to implement your anatomical gift may be taken.  
Please call: Department of Anatomy: 216-368-3430 or 216-368-2255 for the Funeral Director.



# CASE WESTERN RESERVE UNIVERSITY

## School of Medicine

**DEPARTMENT OF ANATOMY - Anatomical Gift Program, WG-46**

10900 Euclid Avenue  
 Cleveland, OH 44106  
 anatomy@case.edu

FORM 2: **Instructions:** complete the entire form, including the appropriate signatures, and return the form to the mail address listed above. Please keep a copy for your next of kin and your physician.

**Name:** (Title) \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Race/ethnicity:** (white, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other, Hispanic or Latino) \_\_\_\_\_

**Resident Address:** \_\_\_\_\_  
 \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_ (County)

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ (mm/dd/yyyy) **Place of Birth:** \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (County)

**Donor's Father's Name:** \_\_\_\_\_ **Donor's Mother's Name:** (before Marriage) \_\_\_\_\_

**Donor's Occupation:** Even if retired \_\_\_\_\_ **Check one:**  
 Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

**Number of Years in School, Elementary 1-12:** \_\_\_\_\_ **College (1+):** \_\_\_\_\_

**Name of Next of Kin:** \_\_\_\_\_ **Relation to You:** \_\_\_\_\_

If next of kin is your wife, give full name before marriage including Maiden Name: \_\_\_\_\_

**Address of Next of Kin:** \_\_\_\_\_

**Telephone number of Next of Kin:** \_\_\_\_\_ **Email of NOK:** \_\_\_\_\_

**Were you in the U.S. Armed Forces?** Yes \_\_\_\_\_ No \_\_\_\_\_ **If Yes, please specify:** \_\_\_\_\_

**Entered Service Date:** \_\_\_\_\_ **Place:** \_\_\_\_\_

**Organization and Service Number:** \_\_\_\_\_ **Branch of Service:** \_\_\_\_\_

**Separation from Service Date:** \_\_\_\_\_ **Type of Discharge (Honorable,etc):** \_\_\_\_\_



**OHIO REVISED CODE  
PERTINENT SECTIONS  
OF CHAPTER 2108**

2108.02

(A) Any individual of sound mind and eighteen years of age or more may give all or part of his body for the purpose specified in section 2108.02 of the Revised Code, the gift to take effect upon his death.

(D) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purpose intended.

(E) The rights of the donee created by the gift are paramount to the rights of the others except when an autopsy is required pursuant to section 313.12 of the Revised Code.

2108.03

Any of the following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(B) An accredited medical or dental school, college or university, for education, research, advancement of medical or dental science, or therapy.

2108.04

(A) A gift of all or part of the body under division (A) of section 2108.02 of the Revised Code may be made by will. The gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

(B) A gift of all or part of the body under division (A) of section 2108.02 of the Revised Code may also be made by any document other than a will. The gift becomes effective upon the death of the donor. The document, which may be a card designed to be carried on the person, shall be signed by the donor in the presence of two witnesses who shall sign the document in his presence. If the donor cannot sign, the document may be signed for him at his direction and in the presence of two witnesses, having no affiliation with the donor, who shall sign the document in his presence. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid.



**CASE WESTERN RESERVE  
UNIVERSITY  
School of Medicine**

FORM 3

**DONOR'S REMAINS**

Do you prefer to have your cremated remains returned to your family?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes to the above, indicate in order of priority the name, address and relationship of the person or entity (eg. funeral home, cemetery) to whom you wish to have your remains delivered:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone #: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone #: \_\_\_\_\_

Please inform any individuals or entities chosen of your decision. If you do not indicate a preference, if the School of Medicine is not able to locate the individuals or entities listed or if the individuals or entities refuse to accept delivery, then your remains will be commingled with other ashes and interred at Riverside Cemetery, located at 3607 Pearl Road Cleveland, OH 44109.

The disposition of your remains may be changed only by your written instruction delivered to Case Western Reserve University School of Medicine, Department of Anatomy WG-46, 10900 Euclid Avenue, Cleveland, Ohio 44106-4930

Date: \_\_\_\_\_

Signature of Donor: \_\_\_\_\_