CASE WESTERN RESERVE UNIVERSITY
School of Medicine

FORM 1

Anatomical Gift
Of

_____

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 decline** 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 interred in the Case Western Reserve University Anatomical Gift Program Memorial grave site 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____:

_____

Signature of Witness Print name of Witness Signature of Donor

_____

Signature of Witness Print name of Witness Signature of Donor

This is a legal document under the Uniform Anatomical Gift Act or similar laws.
Refer to Chapter 2108 of the Ohio Revised Code.
https://codes.ohio.gov/ohio-revised-code/section-2108.01

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

Case Western Reserve University
DEPARTMENT OF ANATOMY
10900 Euclid Avenue
Cleveland, OH 44106 - 4930
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: **Place of Birth:**

(mm/dd/yyyy) (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):

CASE WESTERN RESERVE UNIVERSITY
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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 interred in the Case Western Reserve University Anatomical Gift Program Memorial grave site 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, 10900 Euclid Avenue, Cleveland, Ohio 44106-4930

Date:

Signature of Donor: