



UNIVERSITY of NORTH TEXAS
HEALTH SCIENCE CENTER at Fort Worth
Education, Research,
Patient Care and Service

I, _____, acting as donor, am the _____ (relationship to deceased) of said (deceased's name) _____, do hereby give and grant the body of my beloved _____ to the Anatomical Board of the State of Texas for medical teaching and research purposes. I authorize the delivery of the body of my _____ into the hands of the University of North Texas Health Science Center at Fort Worth (medical school). I do hereby relinquish all rights and claims to the body of my _____ and do grant unto the said medical school full rights to use said body for medical teaching research purposes and ultimately to dispose of the body. In accepting and using this body for the prescribed purposes, and in disposing of the body, the University of North Texas Health Science Center at Fort Worth shall incur no liability and no claim shall arise against that institution in any matter. I fully understand and agree that the scientific research, and educational use of my beloved, may involve an extended period of time to complete, usually two years, but sometimes more than two years in duration. I understand that the medical school reserves the right to not accept the donation at the time of death. The policy of the medical school does not allow it to receive willed bodies that have been autopsied or a body that has tuberculosis, syphilis, or AIDS as determined by a physician. The medical school will bear the transportation cost within Tarrant County. If the deceased is located beyond Tarrant County, transportation costs will be borne by the estate of the deceased. The medical school must receive the body within 6 hours of death or the medical school will be unable to accept the donation. You acknowledge that the policy of the medical school is to cremate all bodies before they are returned to the family or interred by the medical school, and the medical school will charge a cremation fee of \$225.00.

PLEASE CHECK ONE:

___ I DO NOT wish to have cremains returned to family. ___ I WISH to have cremains returned to:

Name of Recipient

Area Code and Telephone Number

Street Address

City State

Relationship to deceased

WITNESS my hand this ___ day of _____, A.D., 20_____.

Street Address

Signature of Donor

City and State

Area Code and Telephone Number

WITNESS (donor signs in the presence of two adult witnesses):

City and State

Signature

City and State

Signature

THIRD PARTY DONOR FORM

WILLED BODY DONATION PROGRAM