



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

## DONATION OF BODY TO MEDICAL SCIENCE

DATE \_\_\_\_\_

TO WHOM IT MAY CONCERN:

BE IT KNOWN THAT I, \_\_\_\_\_,

now residing at \_\_\_\_\_

\_\_\_\_\_ being of sound mind, do hereby will and bequeath, at my death, my body to the Anatomical Board of the State of Texas for the purpose of advancement of medical science and education.

It is my desire that my body be assigned to University of North Texas Health Science Center at Fort Worth. However, to assure that maximum benefit is derived from this contribution, I authorize the Anatomical Board to transfer my body to other teaching or research institutions within the State of Texas, if the institution designated above does not have need of my body. Moreover, I authorize the Anatomical Board of the State of Texas to transport the willed/donated body hereon described out of the State of Texas in the event that the holding institution and the Executive Secretary of the Anatomical Board of the State of Texas have determined that an excess of bodies currently exists in the State of Texas.

**I understand that I cannot be guaranteed that my body will be acceptable at the time of death, and in that event, my survivors will need to make other arrangements for the final disposition of my body. I understand that if I have a contagious disease, AIDS, tuberculosis, syphilis, other communicable disease, my body is damaged by violence at death, an autopsy has been performed, or if I commit suicide, my body will not be acceptable to the Willed Body Program.** If my body is acceptable, I authorize 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 education and research. I fully understand and agree that the scientific research, and educational use of my body may involve an extended period of time to complete; usually, but not necessarily limited to two or more years in duration.

I hereby instruct those who will arrange for disposition of my body to notify the above institution at the following address and phone number so that appropriate arrangements can be made at the time of my death.

### **UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER AT FORT WORTH**

Department Cell Biology and Genetics

3500 Camp Bowie Boulevard

Fort Worth, Texas 76107

Telephone (817) 735-2047

FAX (817) 735-2610

If no answer, after business hours, and holidays, please call (817) 735-2210.

I understand that the receiving institution does not have the facility for family viewing and is obligated to pay only standard fees for embalming and transportation of my body, within Tarrant County from the institution. If my death should occur beyond Tarrant County, my estate will be obligated to pay the difference. Transportation of my body must be by the mortician service designated by the institution; otherwise, my estate will be obligated to pay the transportation expense. The final disposition of my body will be cremation, and a fee of \$225.00 is due for the cremation, at the time of my death.

It is my understanding that final disposition of my body shall be cremation, and State law does not make the return of cremains an institutional requirement.

\_\_\_\_\_ **I DO NOT WISH** to have my cremains returned.

\_\_\_\_\_ **I WISH** to have my cremains returned to:

Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

I hereby relinquish all rights and claims regarding my body, by any person whatsoever, and direct that in accepting and using this body for scientific purposes, and disposing 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 Executive Secretary of the Anatomical Board of the State of Texas. The name and address of this individual may be obtained from the institution to which the body was delivered.

**WITNESS** my hand this \_\_\_\_\_ day of \_\_\_\_\_, A.D., 20 \_\_\_\_\_.

Date of Birth: \_\_\_\_\_ Signed: \_\_\_\_\_

\_\_\_\_\_ Printed Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Signature and addresses of two (2) witnesses, preferably anticipated survivors:

I, the undersigned witness, hereby certify that I am over 18 years of age on this date and that I have witnessed the signature of the Donor above.

**WITNESS:**

**WITNESS:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
City and State

\_\_\_\_\_  
City and State

