CERTIFICATE OF BEQUEATHAL

This is **not** a Contract

University of Utah Body Donor Program

520 Wakara Way Salt Lake City, UT 84112

Business Hours Ph #: 801/581-6728 After Hours/Weekends Ph #: 801/581-2121

http://medicine.utah.edu/neurobiology-anatomy/body-donor-program/index.php

A	В	Designation of Cremains		
To be completed when arranging your own body donation.	Complete this section when donating a body other than self.	Please designate desire for disposition of cremains upon completion of use for medical education and research. (CHECK ONE).		
Print Full Legal Name	Print Full Legal Name	University Donors Grave at Salt Lake City Cemetery		
Street Address	Street Address	2 \ Datum to Family via		
City State Zip I hereby donate my body to be delivered after death to the	City State Zip I hereby donate the body of	 Return to Family via U.S. Mail with signature required. (If checked here, complete info below) 		
University of Utah School of Medicine for legitimate purposes of medical study and research. I stipulate such delivery be made	to be delivered after death to the University of Utah School of Medicine for legitimate purposes of medical study and research.	Full Name		
as soon as possible.	I stipulate such delivery be made as soon as possible.	Street Address		
I am aware certain physical conditions at death may prohibit the Department of Neurobiology & Anatomy from accepting some anatomical gifts.	I am aware certain physical conditions at death may prohibit the Department of Neurobiology & Anatomy from accepting some anatomical gifts. I further state that I am the legal representa-	City State Zip () Area Code Telephone Number 3.) Family will pick up cremains in the Body Donor Program office (If checked here, complete below)		
Signature	tive of the above body donor.			
Date		Full Name		
	Signature	Street Address		
Witness	Date	City State Zip		
(optional) E-mail address	Relationship to Donor	() Area Code Telephone Number		
	Witness	, and dodd Tolopholie Nulliber		

The following information is required for the Body Donor Program to complete the death certificate. Please complete the following as it pertains to the body donor, or ensure any omitted information is readily available to your next of kin or other estate representatives.								
Name: Birth Date:								
ivaille.	First	Middle	Last	Month	Day Year	Birth Place City/State		
	Social Security #			Father's Name		Mother's Full Maiden Name		
				Yes/_N				
	Occupation (prior to retirement)		ement)	Veteran (circle one)		Years of Education / Degree		
Medica	al Histor	r y						
informat	tion you i ment, cai	mighť deem pertir	ent (e.g., he	art by-pass surge	ry, artificial jo	s; please include any health vints, hysterectomy, lens ot need to include any health		
	•	ete both forms. or the donor's pe		should be return	ned to the Bo	ody Donor Program and the		
researc	ch disco	veries, and train	the next ge	neration of scie	ntists and pl	our missions, advance nysicians. Receipts for stantiate your gift.		
						ching and research f Neurobiology and Anatomy.		