RETURN THIS COPY TO AMC

STATEMENT OF DONATION

***Return all three pages to*:**

Anatomical Gift Program MC-135
A lbany Medical College
47 New Scotland Ave
Albany, NY 12208

As authorized by the provisions of the Public Health Law of the State of New York, any of the following persons, in the order of priority stated, when the persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent, or actual notice of opposition by any member of classes listed below, may give the decedent's body to a medical school for educational and/or research purposes. Please **circle** the appropriate letter:

(a) The person designated as the decedent's health care agent
(b) The spouse, if not legally separated from the decedent, or the domestic partner
(c) Children eighteen years or age or older of the decedent;
(d) Either parent of the decedent;
(e) Siblings eighteen years or age or older of the decedent;
(f) Grandparents of the decedent;
(g) Grandchildren eighteen years or age or older of the decedent;
(h) A guardian of the decedent at the time of death;
(i) Any other person having the authority to dispose of the decedent's body:

- Upon its acceptance of the donation, the College will arrange with a contracted funeral home to have my remains transferred to Albany Medical College, within 24 hours of death, and within a **100** mile radius of the Albany Medical College, at College expense (death certificates, obituaries, register books, prayer cards, a memorial service other than AMC's, etc., are not included). If death shall occur outside the 100 mile radius, Albany Medical College will, upon such acceptance, make arrangements for the transportation of my body to the Albany Medical College. In this case, however, the Albany Medical College will reimburse a Funeral Director for the transportation expenses **only**, not to exceed the amount of $300.00; and any additional expenses will be borne by my estate and I have so directed my family and/or the executor or administrator of my estate. If preferred, a specific funeral home may be used however they must agree to the Albany Medical College's payment structure and all additional costs are borne by my estate. If one is requested, the family or heirs should notify us at the time of death.

- It is understood that a determination of the acceptability of my remains will be made at the time of death and that the Albany Medical College reserves the right to **decline the donation** under conditions where there is family dissent, where my remains are deemed unsuitable for educational or research purposes, or for other reasons such as current lack of sufficient physical capacity to accept additional donations. Examples of unsuitability of remains include extreme decomposition, autopsy, infectious disease or weight limitations. In the event Albany Medical College declines my donation, alternate arrangements for the disposition of my body must be made by my family or otherwise on behalf of my estate. If my donation is declined, my heirs or others legally empowered to act in such matters will be solely responsible for the disposition of my remains.

- It is understood that following the donation the Albany Medical College may, if desired, perform tests for infectious diseases or request copies of the decedent's recent medical records for such purposes as to determine the suitability of applicable studies. The Anatomical Gift Program is not empowered to perform an autopsy and does not release findings or medical records.

- It is understood that at times of need, the decedent's remains may be transferred to another medical school or allied health school for the purposes of medical education and/or research, unless notified otherwise, in writing.

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Having read and understood the preceding conditions and affirming that they have, or can be complied with, I direct that the body of:

Deceased_____**Age**_____

Date of birth_____**Social Security #**_____

Address prior to death_____

be delivered to the Albany Medical College within 24 hours after death to be used for the purposes of medical education and/or research purposes.

Following their use for educational and/or research purposes (approximately 12 to 24 months), all bodies are individually cremated. One of the following interment options for the final disposition of the cremains **MUST** be checked:

I would like my cremains interred in one of the Albany Medical College plots:

☐ Albany Rural Cemetery ☐ St. Agnes Catholic Cemetery

Please notify the following individual of the memorial and interment service:
Relationship to you? _____
Name_____
Address_____
_____
Telephone_____

I would like my cremains returned to my family or heirs.

Please notify the following individual when the ashes are available for return:

Relationship to you? _____
Name_____
Address_____
_____
Telephone_____
E-Mail Address _____
(if available)

Alternate individual in event the above cannot be contacted:

Relationship to you? _____
Name_____
Address_____
_____
Telephone_____
E-Mail Address _____
(if available)

Signature_____**Date**_____

Relationship to decedent_____

Witness_____**Witness**_____

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Statistical Information Sheet Concerning Deceased Donor is Required for the Proper Completion of the Death Certificate.
(Please print or type)

Name: First_____ M._____ Last_____ DOB:_____

City & State of Birth_____ SS# _____

Current Address & County_____

Phone # _____ Race_____ Height _____ Weight_____

US Armed Force? No _____ Yes _____ War or Service Dates_____

Usual Occupation (do not enter retired) _____City/St._____

Kind of Business or Industry_____ Homemaker Y_____ N_____

Education Level <8th gr._____ 9th- 12th gr. W/ Diploma _____ 9th- 12th W/GED _____

College: Associate's Degree _____ Bachelor's Degree _____ Doctorate/Professional Degree _____

Fathers Full Name _____ Fathers Place of Birth City & St. _____

Mothers First& Maiden Name _____ Place of Birth City & St._____

Marital Status: _____ Spouse's First & Maiden Name _____

Spouse's Address & Phone # (if different) _____

Physician: Name _____

Address _____

Telephone _____

Medical History and other Pertinent Information is vital to determine the suitability of applicable studies.
This Information will NOT hinder the donation.

Check any of the following which the deceased may have incurred:

☐ Pacemaker ☐ Coronary bypass surgery ☐ Coronary valve replacement

☐ Knee Replacement ☐ Hip Replacement ☐ Abdominal Surgery ☐ Hysterectomy

Please list chronic conditions and any major procedures or surgeriesof which you are aware:

COPY TO BE RETAINED BY INDIVIDUAL MAKING THE DONATION

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(telephone 518 262 5379)

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Telephone_____
E-Mail Address _____
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Signature_____**Date**_____

Relationship to decedent_____

Witness_____**Witness**_____