THIS COPY FOR:
[ ] Medical School
[ ] Donor

UNC SCHOOL OF MEDICINE **Body Donation Program**
CB# 7520 UNC, Chapel Hill 27599 Phone (919)966-1134
Fax (919)966-6354

CERTIFICATE FOR BEQUEATHING BODY BY INDIVIDUAL

In compliance with the Uniform Anatomical Gift Act of the North Carolina General Statutes please complete the following:

I, _____, hereby bequeath (will
(print name)
donate) my body, at my death to the University of North Carolina School of Medicine's Body Donation Program for scientific study and research.

It is also my wish that: (check the appropriate boxes)

[ ] If I die outside the state, my body be offered to the nearest medical school.

[ ] If the University of North Carolina does not accept my body for its scientific and educational purposes, my body be offered to the Commission of Anatomy for distribution to other medical schools.

Medical Information Release:

I will be responsible for completing my physician's and/or health care facility's Release of Protected Medical Information Authorization Form. Upon my death, my physician and/or health care facility will release my medical information to the UNC School of Medicine's Body Donation Program and applicable crematory in order to facilitate the donation of my body and cremation of my remains. In addition, I give the Body Donation Program permission to release my medical information to their faculty, staff and applicable crematory when needed in order to facilitate the preparation and study of my remains for educational purposes and cremation.

Disposition of ashes:

I understand that upon completion of studies my remains will be reduced to ashes (cremated) and the ashes will be returned to my next-of-kin or executor of my estate.

Next-of-kin/Executor: _____

Address: _____

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(over)

Required Signatures:

Donor Signature:_____Date:_____

Address:_____

SSN:___-_____-_____

You are strongly encouraged to provide your Social Security Number (SSN) here so that the University can accurately and timely comply with Federal, State and/or Local government agency reporting requirements, such as to the North Carolina Vital Records Office and to the Social Security Administration. Submission of your SSN on this form is voluntary, however.

City, State, and ZIP:_____Birth Date:_____

_____ _____

Signature of (1) Witness Address (city, state, and Zip)

_____ _____

Signature of (2) Witness Address (city, state, and Zip)

INSTRUCTIONS

This form should be executed in duplicate. The donor keeps a copy, and the original copy should be sent to:

University of North Carolina School of Medicine
Body Donation Program
CB# 7520
UNC - Chapel Hill, School of Medicine
Chapel Hill, North Carolina 27599-7520

At the time of death, notify the University of North Carolina School of Medicine's Body Donation Program to arrange transfer of the body to Chapel Hill, NC. For this purpose, telephone:

Regular working hours:
(Monday through Friday,
8:00am to 5:00pm)

Anatomical Materials Curator
University of North Carolina
School of Medicine's Body
Donation Program
CB# 7520
UNC School of Medicine
Chapel Hill, NC 27599-7520
(919 966-1134)

After working hours, weekends,
and holidays:

_____

Call (919) 966-1134 and follow
the instructions

Body Donation Program
University of North Carolina School of Medicine
CB# 7520
University of North Carolina at Chapel Hill
Chapel Hill, NC 27514
(919) 966-1134, Fax (919) 966-6354

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

In connection with the donation of the body of the donor listed below for medical education purposes, I authorize the Body Donation Program of the University of North Carolina at Chapel Hill School of Medicine to use or disclose the protected health information of

Donor Name:_____Date of Birth:_____/_____/_____

Address:_____City:_____State:____Zip Code _____

Telephone: (___) _____Social Security # (voluntary):_____

UNC HCS Medical Record # (if applicable) _____

to the following classes of individuals or entities: students, faculty and staff of the University of North Carolina School of Medicine, governmental or regulatory agencies, if necessary for public health purposes to report any information about his/her medical status at the time of his/her death, and/or the applicable crematory which will cremate his/her remains.

Information to be disclosed may include: Death certificate or other information relating to the cause of death of the donor, or any information discovered in the course of studying the donor's body. I acknowledge that the data to be released MAY INCLUDE INFORMATION PROTECTED BY LAW. MY SIGNATURE BELOW AUTHORIZES INCLUSION OF INFORMATION PERTAINING TO HIV/AIDS AND OTHER COMMUNICABLE DISEASES. The purpose of the use or disclosure is to facilitate the use of the donor's body for medical education and the cremation of his/her remains.

I understand that:

- I may revoke this Authorization at any time:
  - the revocation will not apply to information that has already been released in response to this Authorization
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Information Management Department.
- I may refuse to sign this Authorization:
  - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire upon the return of the donor's cremated remains to his/her family.

I have read and understand the information in this Authorization form.

Signature of Donor:	
Printed Name:	**Date:**

OR

Signature of Authorized Representative:	
Printed Name:	**Date:**
Authorized Representative's authority to act on the behalf of the donor:	

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SUPPLEMENTARY INFORMATION ABOUT DONOR

Please include the following information, if possible, with the bequeathal certificate to be returned to the Medical Sciences Teaching Laboratories, School of Medicine, University of North Carolina. This information will be helpful in the completion of the death certificate and will facilitate prompt removal of the body.

NAME: _____ SEX: _____
(last) (first) (middle)

ADDRESS: _____
(street, city, state, and ZIP)

COUNTY_____INSIDE CITY LIMITS? [ ] Yes [ ] No

PHONE NUMBER: (____)_____

Please Provide the Last Four Digits of Your Social Security Number (SSN): _____

[ ] Married [ ] Single Spouse: _____
[ ] Widowed [ ] Divorced (wife's maiden name or husband's name)

Date of Birth: _____ Place of Birth: _____
(county and state)

Usual Occupation: _____
(list kind of work done during life, even if retired)

Was donor in the U.S Armed Forces? Highest grade of education completed: _____
[ ] yes [ ] no [Elementary/Secondary (0-12) College (13-17+)]

Father's Name and Birthplace: _____

Mother's Maiden Name and Birthplace: _____

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PHYSICIAN: _____
name and address (street, city, state and ZIP)

ATTORNEY: _____ (____)_____
name telephone

_____
address (street, city, state and ZIP)

Donor's will is recorded in the County of: _____ State of: _____

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This information has been provided by:

[ ] Donor [ ] Other: _____ (____)_____
name telephone

_____
address (street, city, state and ZIP)

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