ANATOMICAL GIFT REGISTRY APPLICATION FORM

Medical College of Wisconsin
Department of Cell Biology, Neurobiology and Anatomy
8701 Watertown Plank Road, Milwaukee, Wisconsin
53226 Phone: (414) 955-8261 | Fax: (414) 955-0047
E-mail: bodydonation@mcw.edu

The laws of the State of Wisconsin permit us to accept the donation of bodies for use in medical education and medical research within our institution or in other scientific and educational institutions within or outside the state. If you choose to donate your body, research that may be done may include, but is not limited to, medical procedure education and/or bodily injury research. If you do not agree to be included in any of these types of education/research, please do not donate your body. When the studies are completed, the remains are cremated. We cannot furnish a report of our findings or the cause of death. This is a non-profit program; therefore we require the donor's estate or family to pay any administrative fees and costs which include: transporting donor to the facility at the time of death, filing of death certificate, cremation permit and cremation.

This form is to be signed by the donor and the next of kin (this term includes spouse) or representative. This document must be signed by the donor and the next of kin or representative in the presence of two (2) witnesses, who must sign this document in the donor's presence.

Return the completed forms (pages 2-4) by mail, fax or email (see information above) and keep a copy of the form for your files, or have a relative retain a copy for future reference.

The Medical College of Wisconsin has the right to refuse acceptance of a body for any reason; including, but not limited to: the circumstances do not permit the use of the body in accordance with the donor's wishes; it is deemed unsuitable for any of our programs (for example, obesity, recent surgery or communicable diseases, etc.). This document is only an application to our program and you should have an alternate plan arranged in the event that we cannot accept your body at the time of death.

We thank you for your interest and generosity in promoting medical education.

MEDICAL COLLEGE OF WISCONSIN

DONOR INFORMATION

PLEASE PRINT ANSWER TO ALL QUESTIONS

1. FULL Name: _____

(First Name) (FULL Middle Name) (Last Name)

2. Sex (check one): ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Is your gender the same as the sex you were assigned at birth? ☐ Yes ☐ No

3. SOCIAL SECURITY number: _____

4. Birth Date: _____

5. Marital Status (check one): ☐ Married ☐ Never Married ☐ Divorced ☐ Widowed

6. Present RESIDENCE Address: _____

City, State, Zip _____

County: _____ Check one: ☐ City ☐ Village ☐ Township

7. State of Birth OR name of Country of Birth: _____

8. Please provide FULL names of BOTH your parents; EVEN IF THEY ARE DECEASED (do not indicate deceased):

Father's FULL Name: _____

(First Name) (FULL Middle Name) (Last Name)

Mother's FULL Name: _____

(First Name) (FULL Middle Name) (MAIDEN Last Name)

9. Race (check one): ☐ White ☐ Hispanic (specify Cuban, Mexican, etc.): _____

☐ Black ☐ American Indian (specify tribe): _____

☐ Asian ☐ Native Hawaiian, Pacific Islander: _____

☐ Other: _____

10. USUAL occupation (specific kind of work during MOST of your lifetime), EVEN IF RETIRED:

SPECIFIC type of occupation: _____ Business/Industry: _____

11. Education: CIRCLE highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE: 1 2 3 4 5+

12. Were you ever in the U.S. Armed Forces (check one): ☐ Yes ☐ No

13. Name of LIVING Spouse: _____

(First Name) (FULL Middle Name) (Last Name) (If applicable, MAIDEN Last Name)

Address if different from No. 6 above: _____

(Number and Street)

_____ (_____) _____

(City, State) (Zip) (Area Code) (Telephone Number)

ACKNOWLEDGEMENT/RELEASE BY NEXT OF KIN OR REPRESENTATIVE

I, being the NEXT OF KIN or REPRESENTATIVE, release all claims to the remains of _____ to be used for medical education/research programs at the Medical College of Wisconsin or at other scientific or educational institutions within or outside the State.

NEXT OF KIN or REPRESENTATIVE Signature: _____ Date _____

PRINTED Name: _____ Relationship:_____

Telephone number: (_____) _____ Email: _____

Address: _____

City, State, Zip: _____

Under Wisconsin law, the surviving spouse, next of kin, family member or other person who assumes custody of the body of the deceased, has the right to rescind the donation of the donor, they also have the right to request a funeral service or other last rites to be arranged by them at their own expense prior to the donor being taken to the Medical College of Wisconsin. The Funeral Home/Director assisting with the arrangements MUST CALL the Medical College of Wisconsin Anatomical Gift Registry for "special instructions" BEFORE the donor is embalmed.

DISBURSEMENT OF REMAINS

TO BE COMPLETED BY NEXT OF KIN OR REPRESENTATIVE - PLEASE SELECT ONE

☐ YES, I wish to have the donor's ashes returned when the studies are completed. I understand that ashes will not normally be returned for up to three (3) years, possibly longer. A letter will be sent to individual/address listed as next of kin or representative when the ashes are ready for return.

☐ As the designated next of kin or representative I do not wish to have the donor's ashes returned to me, but I agree to have them released to the following individual for final disposition:

PRINTED NAME of Alternate Recipient of Donor Ashes: _____

Telephone number: (_____) _____ Relationship: _____

Address: _____

City, State, Zip: _____

☐ NO, I do not wish to have the donor's ashes returned. I understand that the ashes will be buried in a private ceremony under the supervision of MCW officials and clergy.

DONOR DECLARATION

I, _____, being at least 18 years of age and of sound mind, hereby donate my body after death to the Medical College of Wisconsin for use in medical education or medical research programs at the Medical College of Wisconsin or at other scientific or educational institutions within or outside the state. I, my next of kin or representative, will arrange to have the Medical College of Wisconsin notified immediately after my death and my estate or family will pay all applicable administrative fees and transportation charges to have my body delivered to the Medical College of Wisconsin in Milwaukee. I understand and agree that the Medical College of Wisconsin has the right to refuse acceptance of my body at any time for any reason. I have shared my wishes and all of the above information with my next of kin or representative.

This document is only an application to our program and you should have an alternate plans arranged in the event that we cannot accept your body at the time of death.

DONOR'S signature: _____ Date: _____

Donor's Telephone number: (_____) _____ Email: _____

Donor's address: _____ City, State, Zip: _____

WITNESSES DECLARATION

On this _____ day of _____, 20_____, _____ declared to us his/her intention to donate his/her body to the Medical College of Wisconsin, for use in medical education or research programs at the Medical College of Wisconsin or at other scientific or educational institutions within or outside the state. The donor and the next of kin or representative both signed this document in our presence. We then, both signed this document in their presence and in the presence of each other. Each of us declares that the donor is an individual of sound mind.

Witness #1	Witness #2
Signature:_____	Signature:_____
Print Name:_____	Print Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Telephone: (_____) _____	Telephone: (_____) _____

PLEASE NOTE

All required information must be complete before submitting your form

Please return pages 2-4

(See page 1 for mailing information)

REV. Nov 2022