College of Osteopathic Medicine of the Pacific
COMP-Northwest

INSTRUCTIONS

Part I HOW TO COMPLETE THE FORMS

For each person, two copies of the Gift Document need to be signed and dated in the presence of two witnesses. The witnesses will then sign the documents. The Personal Data Sheet should be completed. It provides the necessary information required by the State of Oregon for completing an Oregon State Death Certificate and information that will be of value for our studies.

ALL INFORMATION PROVIDED BY YOU REMAINS CONFIDENTIAL AND SECURE.

A. **Return** University Copy of Gift Document and Personal Data Sheet to:

Western University of Health Sciences
Body Donation Program
200 Mullins Drive
Lebanon, Oregon 97355

B. **Retain** Donor Copy of Gift Document **for your records**. Inform your family, close friends, attorney and physician of your wishes. Be sure they are familiar with Part II below. **Give your family a copy and upon entering a hospital, request a copy of your Gift Document to be attached to your Medical Chart.**

Part II WHAT TO DO WHEN DEATH OCCURS

When death occurs, the Body Donation Program office at Western University of Health Sciences must be notified immediately. This office will arrange to have the decedent transported to Western University. When our representative arrives, they will contact the physician or County Coroner's Office, if necessary. They will also file the Death Certificate with the County Health Department in which the death occurred.

To report a Death, please call: (541) 259-0256

If it is after Program hours (8:30 AM to 4:30 PM Monday through Friday) or a weekend or holiday, please follow the Voice Mail instructions to obtain immediate assistance.

NOTICE: Western University of Health Sciences **RESERVES THE RIGHT TO REFUSE ACCEPTANCE OF A REGISTERED DONOR'S REMAINS under certain conditions.** Among these are: Diagnosis of Creutzfelt-Jacobs Disease, Hepatitis, HIV, or Tuberculosis, Jaundice or amputation, autopsy or major organs harvested, extensive burns, trauma or surgery 4 weeks prior to death. Weight: Men over 235 lbs.; Women over 210 lbs.

Other particular conditions may also preclude acceptance of a registered donor's remains.

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I hereby state that it is my wish to donate my body or a loved one to **Western University of Health Sciences,** immediately upon death, for teaching purposes, scientific research, or such purposes as **Western University of Health Sciences** or its authorized representatives shall, in their sole discretion, deem advisable. The body, when delivered to the University, should be un-embalmed, un-autopsied, and intact. Western University of Health Sciences will perform or have performed any needed embalming.

I agree to inform **Western University of Health Sciences** regarding any changes of address.

Date_____ _____
(Print name of donor)

Signed_____
Donor or Next of Kin

Address_____
(Street Address) (City, State, Zip Code)

My wishes are that the University have the body cremated and:

_____Scattered at Sea **_____Returned to Family**

We, the undersigned witnesses, hereby affirm with our signatures that the above donor or donor family signed and dated this document in our presence.

Witness 1 (signature)_____

Address_____
(Street Address) (City, State, Zip code)

Witness 2 (signature)_____

Address_____
(Street Address) (City, State, Zip code)

In the event of death, call (541) 259-0256, for complete instructions. **UNIVERSITY COPY**

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Witness 2 (signature)_____

Address_____
(Street Address) (City, State, Zip code)

In the event of death, call (541) 259-0256, for complete instructions. **PERSONAL DONOR COPY**

Western University OF HEALTH SCIENCES

College of Osteopathic Medicine of the Pacific
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DONOR

FULL NAME_____

DATE OF BIRTH_____ STATE OF BIRTH_____

SS#_____ MILITARY SERVICE: YES OR NO_____

MARITAL STATUS_____YEARS OF EDUCATION_____

RACE_____USUAL OR LAST EMPLOYER_____

OCCUPATION (NOT retired)_____

KIND OF BUSINESS_____YEARS IN OCCUPATION_____

RESIDENT ADDRESS_____

CITY & ZIP_____YEARS IN COUNTY_____

FULL NAME OF SPOUSE (Maiden)_____

FULL NAME OF YOUR FATHER_____BIRTH STATE_____

FULL NAME OF YOUR MOTHER _____BIRTH STATE_____
(Maiden)

I have completed the personal data above and verify it as accurate. *I also understand that my body may be sent to another medical institution of higher learning that is approved by WesternU for the betterment of medical science.*

Sign_____ **Date**_____ **UNIVERSITY COPY**

200 Mullins Drive, Lebanon, OR 97355 • (541) 259-0200 • FAX (541)259-0201
www.westernu.edu