



Willed Body Program

DONOR PACKET INTRODUCTION & INSTRUCTIONS

Dear Applicant,

Thank you for your interest in donating to the Willed Body Program (WBP) at Western University of Health Sciences. Your generous gift enables us to better instruct our medical students by providing a realistic human anatomy experience, and to further important research. Two or more years are often required to facilitate adequate preservation, study, dissection, cremation, and disposition of cremated remains. The WBP practices only full-body donation, not organ nor tissue donation. Enclosed in this packet you will find the following forms:

- **Release of Remains** - Gives the Willed Body Program permission to transport donor from place of death (*within 100 miles*) to the University (Only required by certain hospitals/facilities).
- **HIPAA Release** – Provides valuable medical information from health care facility to the University, to provide a case history as to pathological conditions the donor may have had (This form is voluntary, and refusal to sign does not preclude donation).
- **Gift Document** – Bequeaths the donor body to the Willed Body Program, and gives us permission to embalm and otherwise prepare the donor for study.
- **Personal Data Sheet** – Provides important vital statistics that are necessary for filing the death certificate and acquiring the disposition permit from the county of death and the State of California.

Please mail the completed Donor Packet to the Willed Body Program (**Attention: Willed Body Program**), at **309 E. 2nd St. Pomona, Ca. 91766**. The Director of the Willed Body Program will determine eligibility and notify the applicant of acceptance or rejection. For those donors **ACCEPTED** into the program, they will receive an acceptance letter and donor wallet card. For those donors **DECLINED**, it is due to stringent guidelines that allow the Willed Body Program to select only those donors that will remain well-preserved and viable for prolonged study, and that are safe for our students to dissect.

CONDITIONS THAT DISQUALIFY ONE FROM FULL-BODY DONATION

- **Prior Embalming/Autopsy**
- **Contagious Diseases** – HIV/AIDS, TB, Hepatitis B & C, MRSA, VRE, COVID-19, CJD/BSE
- **Prior Donation** - Long Bone and Tissue Donation render the donor unusable. **Cornea donation is ok.**
- **Trauma** – Serious injuries, Major surgery in the last month, Chronic wounds, Decubitus ulcers, amputations, Extensive burns
- **Detrimental Medical Conditions** - Pronounced jaundice, Severe Edema, Extreme Contortions/Atrophy of body and limbs, Excessive weight/BMI (**Over 200 lbs.**)

Thank you for considering full-body donation. Please contact the Director of the Willed Body Program with any questions or concerns.



RELEASE OF REMAINS

I, _____, _____
(Print full legal name) (Relationship to deceased)

Attest that I am next of kin (person with the right to control disposition according to California Health & Safety Code, Section 7100), and I give my permission to release the bodily remains of:

(Full legal name of decedent)

From _____
(Name of hospital/facility)

Into the custody of Western University of Health Sciences' Willed Body Program. I understand that any clothing or bedding released with the body will be discarded.

California Health & Safety Code, Chapter 3, Section 7100

The right to control the disposition of the remains of a deceased person, unless other directions have been given by the decedent, vests in, and the duty of interment and the liability for the reasonable cost of interment of such remains devolves upon the following in the order named: (a) An Agent under Power of Attorney for Health Care. (b) The surviving competent spouse. (c) The sole surviving competent adult child or majority of the adult children of the decedent. (d) The surviving competent parent or parents of the decedent. (e) The surviving competent adult person or person respectively in the next degrees of kindred in the order named by the laws of California as entitled to succeed to the estate of the decedent. (f) The Public Administrator when the deceased has sufficient assets.

WARNING: THE PERSON SIGNING THIS RELEASE FOR REMAINS IS LIABLE FOR ALL DAMAGES CAUSED BY ANY UNTRUTHFUL STATEMENTS CONTAINED IN THIS DOCUMENT.

(California Health & Safety Code Section 7110)

Important Note: If the decedent's body is released, and upon arrival to Western University it is discovered the donor presents any of the disqualifying conditions listed on the first page of the donor packet, the acceptance will be reversed, and the next of kin will be responsible for handling all legal and financial responsibilities regarding final disposition of their loved one at a funeral establishment or cremation society of their choice. The next of kin will be responsible for reimbursement of Western University's costs incurred for transportation fees.

I declare under penalty of perjury that the foregoing is true and correct.

Print full legal name _____

Signature _____ Date _____

Address _____



HIPAA RELEASE

Authorization for Disclosure of Protected Health Information

*(Authorization is **NOT required** for enrollment in the Willed Body Program)*

Please check one of the following:

- YES**, my medical records may be requested/reviewed after my death. I have completed the authorization section below.
- NO**, I do not want my medical records to be requested/reviewed *(This form must still be submitted with the application)*.

I hereby authorize my physician of record to release to Western University of Health Sciences' Willed Body Program (after my death) the entire medical record or those portions thereof as determined necessary by the Willed Body Program.

I understand that the medical record will not be used or disclosed for purposes outside the intent and scope of the Willed Body Program. Unless I submit a request to revoke the authorization in writing, this authorization will expire after the study of the body is completed.

Please initial both of the following:

_____ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Willed Body Program and to the appropriate office providing the medical record. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ I understand that signing this form is voluntary and is not required for enrollment in the Willed Body Program.

Full legal name of person signing _____

Signature _____ Date _____

Relationship to Donor _____

Signature of Witness _____ Date _____



GIFT DOCUMENT

I, _____, _____
(Print full legal name) (Relationship to deceased)

Hereby attest that I am the person with the right to control disposition (according to California Health and Safety Code section 7100), and I wish to donate the body of _____
(Print Full Legal Name of Deceased or Pre-Registrant)

To Western University of Health Sciences' Willied Body Program. I understand that if more than **48 hours** have elapsed since the time of death, my donation may not be accepted. I give my permission for Western University of Health Sciences' Willied Body Program to utilize the above-named decedent for teaching, scientific research, or other purposes as the University deems appropriate. I understand the donation period could last **two (2) or more years**. Should acceptance be declined, I agree to assume full legal and financial responsibility for the transfer and disposition of the remains of the above-named decedent, while understanding that Western University of Health Sciences holds no legal nor financial responsibility for final disposition of the deceased. Furthermore, I understand that upon completion of studies, the remains of the donor will be cremated and I will have the option to either have the cremated remains scattered at sea or returned to my family via Priority Mail Express (signature required at time of delivery).

I would like the cremated remains (check one):

Scattered at sea (non-witnessed, off the coast of Orange County)

Returned to family

I agree to inform the Willied Body Program of any **change in my address**, to ensure that the cremated remains be delivered to the correct individual and location.

Note: If, after reasonable attempts, we are not able to contact the family within three (3) years following the cremation, the cremated remains will be sent to the Los Angeles County Coroner for disposition consistent with the County's practices in place at that time. Under no circumstances will the Willied Body Program return any items that are part of the donation such as implants, pacemakers, defibrillators, teeth or inlays, etc. once the donor has been transported to the Program's facilities.

Signature _____ Date _____ Phone # _____

Address _____ Email _____

WITNESS (Name) _____ (Signature) _____

Address _____

DISINTERESTED WITNESS* (Name) _____ (Signature) _____

Address _____

*"Disinterested witness" is one other than spouse, child, parent, sibling, grandchild, grandparent, or guardian, per CA H&S Code Section 7150.10(5)



PERSONAL DATA SHEET

(The following information is used to populate the Death Certificate. Please do not leave anything blank. If you don't know an answer, write "Unknown")

Donor's Full Legal Name: _____

Also known as (A.K.A.): _____

DOB: ____/____/____ State of Birth: _____ SSN: _____
(or Country, if outside U.S.)

Military Service: [] Yes [] No If yes, what branch? _____

Highest Level of Education/Degree Completed: _____
(e.g. 7th Grade, 12th Grade (no diploma), High School Diploma/GED, Associates, Bachelors, Masters, Doctorate)

Marital Status: [] Married [] SRDP [] Never Married [] Divorced [] Widowed
(check one)

Gender: [] Male [] Female [] Non-Binary [] Unknown/Undetermined
(check one)

Donor's Race: _____, _____, _____
(Enter up to 3 races)

Is Donor Hispanic/Latinx/Spanish? [] Yes [] No [] Unknown

If yes, please specify: [] Cuban [] Mexican [] Puerto Rican Other _____

Usual Occupation: _____
(please do not list "Retired", but rather, the occupation worked for most of the donor's life)

Kind of Business: _____ Years in Occupation: _____
(e.g. Education, Road Construction, Grocery Store)

Donor's Address: _____ Years in County: _____

Full Name of Spouse/SRDP: _____
(Last name should be maiden/birth name, not married name)

Full Name of Donor's Father: _____ Birth State: _____

Full Name of Donor's Mother: _____ Birth State: _____
(Last name should be maiden/birth name, not married name)