Western University
OF HEALTH SCIENCES
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, one of whom must be a disinterested party 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 a 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.

Please know that by registering with our program that you are only enrolled and additional screening will need to be done at the time of death prior to acceptance. 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 and Relationship

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. One must be disinterested party.

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**

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

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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.*

Please know that by registering with our program that you are only enrolled and additional screening will need to be done at the time of death prior to acceptance. Initials

Sign_____ Date_____ UNIVERSITY COPY

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Family contact information

Next of Kin/Executor of Estate Contact Information

Name: _____

Relationship to donor: _____

Street address: _____

City: _____ State: _____ Zip: _____

Telephone number(s): _____

Email address: _____

Alternate Contact Information

Name: _____

Relationship to donor: _____

Street address: _____

City: _____ State: _____ Zip: _____

Telephone number(s): _____

Email address: _____

University Copy

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COMP-NW Willed Body Program Donor Health Survey

The College of Osteopathic Medicine of the Pacific Northwest (COMP-Northwest) is committed to the education of future health care providers. Your contribution will provide students with the best education possible. During the utilization of the donor patient, research may be conducted for the purposes of advancing medicine. In order to impact the future of medicine, we will need as much information as you are willing to provide about the patient's health history. All information provided will be kept confidential and will be used for educational/research purposes only.

First Name: _____ Date and Place of Birth: _____
Gender: □ Male □ Female
Height: _____ Weight: _____
Race: _____ Are you of Hispanic ethnicity? □ Yes □ No
Blood type (if known): _____

Allergies (Medication/food): ***Reaction to allergy:***

_____ _____

Medication list: (please list name/dose/frequency if known):

_____
_____
_____
_____

Lifestyle

Alcohol: □ None □ Yes If yes, what kind & how many drinks/day _____frequency/week
Tobacco: □ None □ Yes
Chew or smoke?_____ If yes, how many/day _____ Since _____
Caffeine: □ None □ Yes If yes, how many/day _____
Recreational Drugs: □ None □ Yes If yes, what kind_____ How many/day _____
Do you exercise? □ Yes □ No If yes, how much?_____

Social History:

Work: □ Employed □ Unemployed □ Retired □ Disabled
Current Occupation _____
Marital Status: □ Married □ Single □ Divorced □ Domestic Partner
Sexual preference: □ Men □ Women □ Both
Children (age):_____
Hobbies:_____

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Past Medical History: (please circle any that apply)

Heart Disease (including: Coronary Disease, MI/heart attacks, Congestive Heart Failure, Atrial Fibrillation, Angina, Valve Disorder)
Stroke or Seizures
Diabetes (Type 1 or Type 2)
Thyroid Disease (Low or High)
High Blood Pressure
Blood Clots
High Cholesterol
Hepatitis (A, B, C)
HIV / AIDS
Cancer (type)
COPD (Emphysema, Bronchitis)
Asthma
Depression
Bipolar Disorder
Anxiety
Arthritis
Gout
Osteoporosis

Family History: (please indicate deceased or alive, medical issues and age)

Father:_____ Mother:_____
Sibling(s):_____

Past Surgical History (indicate date if known)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your participation and interest in the advancement of medical sciences.

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