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 Creutzfeld-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.
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.
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)

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.

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. PERSONAL DONOR COPY

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

www.westernu.edu
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
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: ____________________________
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 If yes, how many/day ______ Since _______________
Chew or smoke? ______
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: _____________________________________________________________________
Past Medical History: (please circle any that apply)
Heart Disease (including: Coronary Disease, MI/heart attacks, Congestive Heart Failure, Atrial Fibrillation, Angina, Valve Disorder)
Thyroid Disease (Low or High)
High Cholesterol
Cancer (type)
Depression
Arthritis

Stroke or Seizures
High Blood Pressure
Hepatitis (A, B, C)
COPD (Emphysema, Bronchitis)
Bipolar Disorder
Gout

Diabetes (Type 1 or Type 2)
Blood Clots
HIV / AIDS
Asthma
Anxiety
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.