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.

UNIVERSITY COPY
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

Chew or smoke? ________ If yes, how many/day _____ Since ________________

Caffeine: □ None □ Yes

Recreational Drugs: □ None □ Yes

Do you exercise? □ Yes □ No

If yes, what kind _________ How many/day ____________

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)
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.