DONALD AND BARBARA
ZUCKER SCHOOL *of* MEDICINE
AT HOFSTRA/NORTHWELL

Consent for Whole Body Donation

(to be completed by next of kin/legally authorized representative)

I, _____, am the next of kin/legally authorized representative of

_____ (the donor). As such, I release the whole body remains (or any part thereof) of the donor to the Whole Body Anatomical Gift Program ("Gift Program") of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell for educational and/or research purposes. In so doing, I give permission for embalming of the remains as needed for study.

I have read the Gift Program documentation and agree to abide by its procedures and policies regarding whole body donation.

I authorize the Gift Program to transfer the donor's remains to another institution legally authorized to receive anatomical gifts in the event that the purpose of medical education and/or research would be best served by this action. I understand that anatomical studies generally take between one and three years, and that some portions of donations may be retained for longer periods of time for archival purposes.

I authorize that the remains be cremated at a licensed in-state crematory at the conclusion of anatomical studies at the expense of the Gift Program. After cremation, I request that the remains be: ***(Check ONE of the following two statements.)***

_____ Scattered at sea.

_____ Returned to the person listed below, who will assume responsibility for them. ***The remains should be made available to:*** *(Please print.)*

Name: _____ Relationship to donor: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Phone: _____ – _____ – _____ Email: _____

I agree to the above conditions and the policies and procedures of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Whole Body Anatomical Gift Program. This form must be signed by a witness.

Printed Name (next of kin/authorized representative): _____ Relationship to donor: _____

Address: _____ City: _____ State _____ ZIP code: _____

Email: _____

Signature of Next of Kin/Legally Authorized Representative: _____ **Date:** _____

Witness

Printed Name: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Email: _____

Witness Signature: _____ **Date:** _____

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White: Return to Gift Program **Yellow: Retain for Your Records**

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