Declaration of Consent | Whole Body Release Form

Wake Forest University
School of Medicine

Center for Experiential & Applied Learning/Whole Body Donation
1 Medical Center Blvd, Winston-Salem, North Carolina 27157-1040
336-716-4369 | 336-716-2447 (fax) | bodydonationAHWFB@advocatehealth.org

RETURN SIGNED FORM BY FAX OR EMAIL
TO COMPLETE BY DOCUSIGN, PLEASE CALL 336-716-4369

Signature on this form grants permission to release the decedent to Wake Forest University School of Medicine and authorizes delivery or dispersal of the cremated remains as directed.

SIGNATURE ON THIS FORM MUST NOT BE DATED PRIOR TO THE DEATH OF THE DONOR.

This form is only valid when signed by the legal next of kin AFTER death has occurred.

The following steps **are required** to process an anatomical donation:

1. Signature on this release form must be processed by the ***legal next of kin***. This is a specific designation outlined by statute in the State of North Carolina. Where there are multiple siblings, additional signatures may be required.
2. Prior to authorizing donation, our staff will qualify condition by telephone with authorized healthcare personnel. For contact during operating hours (8:00 AM – 5:00 PM, M-F), please call **336-716-4369**. Outside those hours, please contact **336-716-2011** and request that the operator page on-call staff for whole body donation.
3. Upon qualifying assessment with healthcare personnel, the next of kin is financially responsible for transport to our facility. With contact after hours, arrangement for transport must include appropriate storage until scheduled delivery. *On-call staff may provide assistance to identify a transport/funeral service able to manage both transport and overnight storage.*
4. PLEASE REMOVE AND SECURE ALL PERSONAL PROPERTY. Only cremated remains will be returned by our program.
5. The following information is requested prior to confirming or receiving a scheduled delivery:

Information to Identify Donor:

(First Name)		(Middle Name)		(Last Name)	(Suffix) ☐JR ☐SR ☐_____
(Date of Birth)	(Date of Death)	(Sex)	(Social Security Number)	(Marital status – please check one) ☐MARRIED ☐DIVORCED ☐WIDOWED ☐NEVER MARRIED ☐LEGALLY SEPARATED	(Number of surviving children)
(Name of facility where death occurred OR address of private residence where death occurred)				(With death outside a medical facility, please identify hospice or primary care provider)	

6. Cremation will not incur cost to the family. WFUSM will return the cremated remains as directed below:
   ***DO YOU WISH TO RECEIVE RETURN OF THE CREMATED REMAINS? (PLEASE ENTER "YES" OR "NO" IN THIS BOX:)** ☐

Requested Delivery Address for Return of the Cremated Remains:

(Name of Recipient or Funeral Home Receiving Cremated Remains)	(Phone Number for Recipient)
(Mailing Address – *please include street name and number, city, state and zip code*)	

In the event of a delivery failure, WFUSM will attempt contact with the legal next of kin. After a period of 12 months, cremated remains will process for dispersal according to state regulations

7. The following section must be completed by a party recognized by the State of North Carolina to hold authority. **Witness** signature must be provided by a person unrelated by blood or marriage. For questions, call 336-716-4369.

Authorized Signature(s) from Legal Next of Kin and Witness **(Healthcare and/or funeral service professionals may serve as witness):**

(PRINTED NAME OF **SIGNATORY**)	(Signature)	(Date)
RELATIONSHIP TO DONOR: ☐SPOUSE ☐PARENT ☐CHILD* (please complete attestation @ right) ☐SIBLING* (please complete attestation at right) ☐HCPOA** (please complete attestation at right) ☐SPECIFY OTHER RELATIONSHIP: _____	***WITH SIGNATURE BY ONE OF MULTIPLE CHILDREN OR SIBLINGS TO THE DONOR:** ☐If signatory is a **CHILD of the donor**, signatory confirms that **all surviving children of the donor agree to donation** ☐If signatory is a **SIBLING to the donor**, signatory confirms that **all surviving siblings of the donor agree to donation** ****WITH SIGNATURE BY HCPOA:** ☐If signatory is named HCPOA, signatory confirms that **HCPOA agreement includes specific authority for disposition of the remains**	
(**Contact information for signatory** – *please include street name and number, city, state and zip code*)		EMAIL PHONE
(PRINTED NAME OF **WITNESS**)	(Signature of **Witness**)	(Date)
(Healthcare facility or funeral service that employs witness in this context/Residence address for personal contact)		(Facility phone number/Phone contact for personal witness)

Thank you for your support of medical education through whole body donation. Please retain this form as your record of disposition. You may contact with any questions to 336-716-4369.

every body gives hope

For updated terms and conditions, please access the most current version of this document at school.wakehealth.edu/whole-body-donation.