Declaration of Consent / Whole Body Release Form

Wake Forest University
School of Medicine

Whole Body Donation Program
Center for Experiential & Applied Learning
1 Medical Center Blvd, Winston-Salem, NC 27157-1040
336-716-4369 | Fax 336-716-2447
bodydonationAHWFB@advocatehealth.org

PRIOR INTENT IS NOT REQUIRED FOR DONATION.
An intent prior to death documents the donor's wishes. After death, the legal next of kin or HCPOA must complete and sign this form to authorize donation.

A. OPTIONAL PRIOR INTENT - COMPLETED BY THE DONOR BEFORE DEATH

I wish to donate my body at the occurrence of my death to the Whole Body Donation Program at Wake Forest University School of Medicine.
I understand that my legal next of kin/Healthcare Power of Attorney (HCPOA), as defined by NCGS 130A-420(b), must authorize donation after my death.

SIGNATURE	PRINTED FIRST NAME	PRINTED LAST NAME	DATE

After completing above, give a copy to your next of kin/HCPOA and/or ask your primary care provider to scan it into your patient record. Section A alone does not authorize donation.

B. AUTHORIZATION AT TIME OF DEATH - COMPLETED BY LEGAL NEXT OF KIN or HCPOA

- ***By signing Section E after the pronouncement of death, the legal next of kin or HCPOA grants permission to release the decedent to Wake Forest University School of Medicine (WFUSM) and authorizes return or dispersal of cremated remains as selected in Section F. Authorization is subject to program eligibility review and applicable law.***
- ***When there are no surviving next of kin or HCPOA and a copy of this form (signed by the intended donor) is in the patient record at time of death, donation may proceed after verification of no surviving next of kin or HCPOA by healthcare personnel. Pre-arranged and pre-funded transport for delivery to our program, as arranged through a licensed funeral service, is <u>required</u>.***

C. DONOR INFORMATION AT TIME OF DEATH

Full legal name (first, middle, last)	Suffix (Jr/Sr/etc.)	Date of death	Date of birth	Social Security number

Sex
☐ FEMALE
☐ MALE

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married ☐ Legally Separated

Number of surviving children: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Street Address where death occurred or facility name	City	State	Zip

If death occurred while under hospice care, name of hospice managing end of life care	Name of contact at healthcare facility or hospice to verify condition (first/last)	Contact phone number

D. PROCESS AND DISPOSITION

1. Contact the Whole Body Donation program by calling 336-716-4369, Monday - Friday, 8:00 am - 5:00 pm; Overnight and Weekends: 336-716-2011.
2. Healthcare personnel must verify donor's condition [includes charted or estimated height/weight, communicable/infectious condition(s), trauma/wounds, contracture/amputation/edema-ascites].
3. Transport to the program must be arranged and paid for by the legal next of kin or HCPOA. Program staff will coordinate delivery with the funeral or transport service selected during arrangement.
4. There is no cost for cremation and return or dispersal of the cremated remains.

E. AUTHORIZED SIGNATURES

Printed name of signatory (first, middle, last)	Suffix (Jr/Sr/etc.)	Relationship to donor: ☐ Spouse ☐ Parent ☐ Child* ☐ Sibling* ☐ HCPOA** ☐ Other (please detail)_____
		* Child or sibling: Signatory confirms all surviving members of this class agree to donation. ** HCPOA: Signatory confirms specific authority for disposition of remains.

Street address of signatory	City	State	Zip	Phone

Signature	Date (valid only <u>after</u> death)	Email

WITNESS (MUST BE UNRELATED BY BLOOD OR MARRIAGE) ***CONSENT IS USUALLY WITNESSED BY HEALTHCARE OR FUNERAL SERVICE CONTACT***

Printed name of witness	Signature of witness	Date of witness signature

Name of hospice, healthcare facility, or funeral service serving as witness to this donation	Street address of witness or facility serving as witness to this donation

City	State	Zip	Phone of witness or facility serving as witness

F. INSTRUCTIONS FOR CREMATED REMAINS - CHECK ONE

☐ **RETURN cremated remains to the recipient or funeral service named below**
☐ **DISPERSE cremated remains per state regulations**

Recipient or funeral service name	Recipient phone

Mailing address (street address or PO box)

City	State	Zip

If delivery fails, WFUSM will attempt to contact the legal next of kin. After 12 months, the cremated remains will be dispersed according to state regulations.

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

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

every **body** gives hope