THE UNIVERSITY OF ARIZONA

- **Please mail all four original pages to:**
  WILLED BODY PROGRAM, P.O. Box 245045 Tucson, AZ 85724
- Make photocopies for your family, physician and for your records
- If you have additional questions, please call (520) 626-6083

FORM 1 of 4: PERSONAL INFORMATION

This form is for the collection of the data needed to complete the Arizona Certificate of Death

Date: _____ Telephone number: _____

Full name of donor (print): _____
First Middle Last

Mailing address: _____
Street number Street Unit/Apt/Space

City, State, Zip: _____

If physical address is different from mailing address, list physical address:

_____

County of residence: _____ ; Within city limits (Select one): ☐ Yes ☐ No

On a reservation (Select one): ☐ Yes ☐ No ; If "Yes," please specify: _____

Date of birth: _____; Select one: ☐ Male ☐ Female
Month Day Year

Place of birth: _____ ; Country of Citizenship: _____
City County State

Donor's Social Security Number: _____; U.S. Veteran (Select one): ☐ Yes ☐ No

Year AZ residency began: _____ ; State donor resided in before AZ: _____

Current marital status: ☐ Never married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If married, spouse's full name (wife's maiden name): _____
First Middle Last

Donor's father's full name: _____
First Middle Last

Donor's mother's full name (maiden name): _____
First Middle Last

Primary occupation prior to retirement: _____

Occupation's business or industry: _____

Highest level of education/degree: _____

Race (Select all that apply): ☐ White ☐ Black ☐ American Indian (Specify Tribe): _____
☐ Mexican ☐ Spanish ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic (Specify): _____
☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Samoan
☐ Native Hawaiian ☐ Other (Specify): _____

THE UNIVERSITY OF ARIZONA

- **Please mail all four original pages to:**
  WILLED BODY PROGRAM, P.O. Box 245045 Tucson, AZ 85724
- Make photocopies for your family, physician and for your records
- If you have additional questions, please call (520) 626-6083

FORM 2 OF 4: MEDICAL QUESTIONNAIRE

Donor name: _____

Date of birth: _____ Height: _____ Weight: _____

Surgical history:

_____

_____

_____

_____

_____

_____

_____

Major health problems:

_____

_____

_____

_____

_____

_____

_____

Any other information or advice you would like to give those you will be teaching:

_____

_____

_____

THE UNIVERSITY OF ARIZONA

- **Please mail all four original pages to:**
  WILLED BODY PROGRAM, P.O. Box 245045 Tucson, AZ 85724
- Make photocopies for your family, physician and for your records
- If you have additional questions, please call (520) 626-6083

FORM 3 OF 4: AUTHORIZATION FOR ANATOMICAL DONATION

I, _____, hereby offer the use of my body after death to the University of Arizona College of Medicine for health professional education and research. Once accepted, my body shall be used for health professional education and research as determined by the University. Such determination may include transporting my body to another educational institution for health professional education and research. I or my next of kin/representative cannot specify the use of which my body will be used. Once my body is received by the University, I understand that my donation cannot be revoked by my next of kin/representative as defined in A.R.S. § 36-849. My body may be tested for Hepatitis B, Hepatitis C and HIV upon arrival at the University. My body may be chemically preserved for a substantial period of time or may be used in an un-embalmed state as anatomical material. Such uses may include dissection, medical procedures, physical examinations, and may be used for more than one purpose. Parts of my body such as tissue, organs, limbs or skeletal material may be removed and separated from the whole. Upon conclusion of my participation, or if it is determined that for any reason my body cannot be used by the University, my body shall be cremated or undergo disposition by any legal means. I understand that my next of kin/representative can request the return of my cremated remains at the time of my death and that the return may take up to two years. If my next of kin/representative does not request the return of my cremated remains, I understand that my cremated remains will be scattered by the University in accordance with Arizona State laws without the possibility of recovery and without notification. I also understand that certain anatomical and/or pathological structures that benefit health professional education and research may not be returned to the whole for disposition.

I understand that the University of Arizona reserves the right to refuse my donation for any reason at the time of my death. If this situation arises, my designated next of kin/representative will be required to make alternate arrangements. I also understand that I may revoke this document any time prior to my death pursuant to A.R.S. § 36-845. The University of Arizona reserves the right to revise policies and procedures at any time without notification, acting in compliance with Arizona State laws.

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding of and agreement to the information and policies listed on the Donor Information and Policy Guide.

_____

Signature of donor Date

_____

Printed name of donor

WITNESSES **(YOU MUST HAVE TWO WITNESS SIGNATURES)**

We, the undersigned, have witnessed the signing of this document by the donor as set forth in A.R.S. § 36-844.

_____

Signature of witness Date

_____

Printed name of witness

_____

Signature of disinterested witness Date
(Cannot be a family member)

_____

Printed name of disinterested witness

THE UNIVERSITY OF ARIZONA

- **Please mail all four original pages to:**
  WILLED BODY PROGRAM, P.O. Box 245045 Tucson, AZ 85724
- Make photocopies for your family, physician and for your records
- If you have additional questions, please call (520) 626-6083

FORM 4 OF 4: CONTACT INFORMATION

Donor name: _____

Please note: This information is required in order to verify death certificate information at the time of death.

Next of kin/Representative 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: _____