



COLLEGE OF MEDICINE TUCSON

Willed Body Program

- Please mail all five 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.
Please review the information carefully to ensure accuracy.*

Date: _____ Telephone number: _____

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

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

City, state, ZIP code: _____

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: _____ ; Year AZ residency began: _____
City County State

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

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): _____



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FORM 2 of 4: MEDICAL QUESTIONNAIRE

Donor name: _____

Date of birth: _____ Height: _____ Weight: _____

Surgical history:

Please list any major surgeries you have had, including any surgeries that removed an organ or body part.

Major health conditions:

Please list any major or ongoing health conditions you have or have had.

Please share any additional information, experiences, or advice you would like to pass along to those who will be learning from your donation.



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FORM 3 OF 4: AUTHORIZATION FOR ANATOMICAL DONATION

I, _____, hereby make an anatomical gift of my body after death to the University of Arizona College of Medicine for health professional education and research. If accepted, my body shall be treated with respect and dignity and shall be used for health professional education and research as determined by the University of Arizona. This may include transfer to another accredited educational institution. Neither I nor my next of kin/representative may direct or restrict the specific educational or research use of my donation.

My body will be tested for hepatitis B, hepatitis C, and HIV upon arrival at the University of Arizona. My body may be chemically preserved for a substantial period of time or used in an unembalmed state. Such uses may include dissection, medical procedures, physical examinations, and other activities supporting health professional education and research. My body may be used for more than one purpose. Parts of my body, including tissues, organs, limbs, or skeletal material, may be removed and separated from the whole. Certain anatomical and/or pathological structures may be retained for continued use in health professional education and research and may not be returned to the whole for final disposition. Photographs, images, and other digital representations of my body or anatomical structures may be created, used, and retained to support health professional education and research in accordance with University of Arizona policies. Educational or research activities involving my donation may contribute to the development of educational materials, technologies, medical devices, or other products that may be commercially distributed or sold. I understand that neither I nor my next of kin/representative will receive compensation or other financial benefit from such products. I understand that future advances in health professional education and research may result in uses of my donation that are not known or anticipated at the time of my enrollment.

Upon completion of my participation, or if it is determined after my body has been accepted that it cannot be used for health professional education and research, my body will be cremated or another lawful method of final disposition may be used. I understand that my preference regarding the return of my cremated remains will be documented on my enrollment form. The return of my cremated remains, if requested, may take up to two years. If my cremated remains are not returned, I understand that they will be scattered by the University of Arizona in accordance with Arizona law without the possibility of recovery or further notification.

I understand that I may revoke this anatomical gift at any time prior to my death in accordance with A.R.S. § 36-845. Once my body has been accepted by the University of Arizona, this anatomical gift may not be revoked by my next of kin/representative as provided in A.R.S. § 36-847.

Acceptance of my donation will be determined at the time of my death and the University of Arizona reserves the right to decline my donation in accordance with its policies. If my donation is not accepted, my designated next of kin/representative will be responsible for making alternate arrangements.

The University of Arizona reserves the right to revise its policies and procedures in accordance with applicable law without requiring a new authorization.



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By signing below, I certify that I am 18 years of age or older; that I am of sound mind, competent to make the decision to donate, and free from duress or undue influence; and that I have read and understand this Authorization for Anatomical Donation. I further acknowledge that I have read and understand the Donor Information and Policy Guide and that my donation is subject to those policies and to applicable Arizona law, including the Revised Uniform Anatomical Gift Act, codified under A.R.S. §§ 36-841 through 36-864.

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 consistent with the witnessing standard prescribed by 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

FINAL DISPOSITION OF CREMATED REMAINS

Please initial **ONLY ONE** of the following elections:

_____ Permanent donation, with no return of cremated remains

_____ Return of cremated remains to:

Name of recipient: _____

Relationship to donor: _____

Contact phone: _____

Address of recipient: _____

City, state, ZIP code: _____



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FORM 4 of 4: NEXT OF KIN 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: _____