Idaho State University

Anatomical Donation Program
921 S. 8th Avenue, Stop 8007
Pocatello, Idaho 83209-8007
208-282-4150

NAME OF DONOR : _____

Upon death, telephone Wilks Funeral Home 208-238-8000 any time, or for questions during office hours, the Department of Biological Sciences at ISU, 208-282-4150

I hereby declare my wish to donate my body upon death to Idaho State University (ISU) as an anatomical gift to be preserved and used for teaching, training and research in the health professionals programs. Upon completion, typically up to four years after acceptance into the program, I authorize my body to be cremated and interred for final disposition, or returned to a designated person. I agree that the University may keep any of my body parts indefinitely for continuing educational purposes.

I understand that the University reserves the right, under circumstances described in "who may donate," to decline the donation, in which case the authorizing agent must make alternate arrangements for the final disposition including transportation costs and all associated expenses.

DONOR/DURABLE POWER OF ATTORNEY/NEXT OF KIN/DONOR AGENT:

Name of Donor:_____ Date of Birth:_____

Residential Address: _____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Cell Phone:_____ Home Phone:_____

Donor or Authorizing Agent Signature: _____ Date:_____

Printed Name:_____ Relationship:_____

The Authorizing Agent acknowledges Idaho State University is relying upon the accuracy and truthfulness of the representation of the Authorizing Agent made above. The Authorizing Agent agrees to indemnify and hold harmless Idaho State University from any and all claims or causes of action arising or related in any respect to my designation above.

_____*initial*

SIGNATURE WITNESS #1:

Witness Signature: _____ Printed Name:_____ Date: _____

Address:_____ City:_____ State:_____ Zip:_____ Phone:_____

SIGNATURE WITNESS #2:

Witness Signature: _____ Printed Name:_____ Date: _____

Address:_____ City:_____ State:_____ Zip:_____ Phone:_____

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NAME OF DONOR : _____

GUIDELINES: ***please read and initial each numbered item. Complete with signature and date.***

1._____Application to the ISU Anatomical Donation Program (the Program) does not constitute acceptance. Every effort will be made to accept the donor body, however the Program or its representatives may, at its sole discretion decline a donation. The authorizing agent will be prepared to make alternative disposition arrangements (including all associated expenses) in the event that the donation is declined.

2._____The Program encourages donors to share their wishes with family members or next of kin/donor agents and resolve any issues or concerns. If at the time of death next of kin/donor agent raise objections to the donation, the Program will decline the donation.

3._____If the donor has executed a trust or living will, durable healthcare power of attorney or related document, the Program encourages the donor to share with any executor/beneficiary or attorney the donor's intentions so they may be properly documented.

4._____Once accepted, the donation will be utilized in a manner determined exclusively by the Program. When donating, donors and/or durable power of attorney/next of kin/donor shall not designate the manner to which the body, or parts thereof, will be put to use.

5. _____The donor or next of kin is requested to provide access to the donor's medical history for enhancement of teaching and research, including if possible such documentation as available X-rays, CT scans, MRIs, EKGs, etc.

6._____The donated body may be used for more than one purpose. Parts of the body may be retained indefinitely for additional teaching and research. These parts will be cremated separately and at a different time from the rest of the body and they will be disposed of in accordance with the laws of Idaho and are non-retrievable.

7._____All medical and dental implants and devices that arrive with the body (e.g., dentures, caps, pacemakers, prosthetic joints) will remain with the body and are non-retrievable.

8._____In most cases the costs of transportation to collect the donated body is covered by the Program. If another funeral home is employed, all costs associated with services, storage and transportation by the funeral home are the responsibility of the donor's durable power of attorney/next of kin/ donor agent.

SIGNATURE OF DONOR/DURABLE POWER OF ATTORNEY/NEXT OF KIN/DONOR AGENT :

Signature: _____ Printed Name:_____ Date: _____

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NAME OF DONOR : _____

FINAL DISPOSITION:

I (*Donor/Durable Power of Attorney/Next of Kin/Donor Agent*)_____, grant the ISU Anatomical Donation Program to act as Authorizing Agent for final disposition of my/or decedent's body. I give the Program permission to retain parts of my body for continued education, training and research. I understand that upon completion, these body parts will be cremated separately and at a different time from the rest of my body. These remains are non-retrievable.

CREMATED REMAINS: ***Please initial one of the two options.***

1._____ I elect NOT to have the cremated remains returned. The Program will dispose of the cremated remains in accordance with the laws of Idaho.

2. _____ I elect to have the cremated remains returned. I understand cremated remains are typically returned within four years of acceptance into the Program. Designee will be notified prior to the return of cremated remains. I understand and agree to pay shipping and handling costs (between $150 to $175) at that time. I also understand that if remains are not claimed within 90 days of notification, the remains will be disposed of in accordance with the laws of Idaho. I direct the Program to ship the cremated remains, enclosed in a temporary urn, through the U.S. Postal Service, Priority Mail Express Service to the following recipient at the address listed below (P.O. Box is not acceptable):

Name:_____

Street Address_____

City_____State_____ Zip_____

SIGNATURE OF DONOR/DURABLE POWER OF ATTORNEY/NEXT OF KIN/DONOR AGENT :

Signature: _____ Printed Name:_____ Date: _____

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NAME OF DONOR : _____

PERSONAL INFORMATION:

Donor's Full Name:_____ Date of Birth:_____

Resident Address:_____ City:_____ State:_____ Zip:_____

Gender:_____ Place of Birth:_____ Ethnicity:_____

Father's Full Name:_____ Father's Birthplace:_____

Mother's Full Maiden Name:_____ Mother's Birthplace:_____

Marital Status: ___Married ____ Divorced ____Widowed ____Never Married

Spouse's Name:_____ Primary Occupation:_____

Education/Degree:_____ Height: _____ Weight: _____

SURGICAL HISTORY :

_____

_____

MEDICAL HISTORY :

_____

_____

CIRCLE THOSE THAT APPLY :

Heart Disease	TB	Hypertension	Stroke
Diabetes	Polio	Kidney Disease	Liver Disease
Arthritis	Epilepsy	Cancer, Type:_____	

HISTORY OF (CIRCLE ALL THAT APPLY) :

Active TB Hepatitis B Hepatitis C HIV/AIDS Creutzfeldt-Jakob MRSA/VRSA

PACEMAKER : YES NO

CIRCLE THOSE THAT APPLY :

Deformity Amputation Organ Removal Transplant Specify:_____