Stanford MEDICINE | Anatomical Gift Program

DONOR REGISTRATION FORM

Please complete the information required below, and then sign, and date the form. Two witness signatures are required for registration. We encourage you to make a copy of the signed document for your own records. We recommend you inform your family, caregivers, physician, and attorney of your wishes to donate to the Stanford Anatomical Gift Program.

Return the completed form to:

Stanford Anatomical Gift Program
Stanford School of Medicine
269 Campus Dr.
CCSR 0125, MC 5140
Stanford, CA 94305

Alternatively, you may fax the completed form to us at 650-725-8668 or email it to us at anatomicalgp@stanford.edu
This document will be scanned and preserved electronically.

LEGAL NAME: _____
First Middle Last

DATE OF BIRTH: _ _ /_ _ / _ _ _ _

PHONE #: _____ EMAIL: _____

MAILING ADDRESS: _____
Street City State Zip

Medical/Healthcare Power of Attorney (if applicable)

NAME: _____

PHONE #: _____ EMAIL: _____

MARITAL STATUS

- ☐ Never Married
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Registered Domestic Partnership

Full Name of Spouse (Maiden if applicable): _____

PERSONAL INFORMATION

- ☐ Caucasian/White
- ☐ Black or African American
- ☐ Hispanic, if YES please specify: _____
- ☐ Asian
- ☐ American Indian
- ☐ Other (specify): _____

Sex (Male, Female, Non-Binary, Unknown): _____

Primary Occupation (prior to retirement): _____

Type of Business or Industry: _____

Years in Occupation: _____

Highest Level of Education: _____

Birthplace: _____

FAMILY INFORMATION

Full Name of Father/Parent: _____

Birthplace of Father/Parent: _____

Full Maiden Name of Mother/Parent: _____

Birthplace of Mother/Parent: _____

VETERAN STATUS

Are you a US Veteran?

YES NO

Branch of US Armed Forces: _____

Please Initial each item below to confirm you have read and understood each requirement.

_____ initials — I acknowledge that my registration with the Stanford Anatomical Gift Program is not a guarantee of acceptance into the Program and that my donation may be declined by the Program at the time of my death.

_____ initials — I agree that it is at the discretion of the Stanford Anatomical Gift Program Coordinator to accept or decline my donation at the time of my death.

_____ initials — I agree that my donation will be declined if I am positive for any infectious or contagious illnesses including but not limited to: HIV, Hepatitis B, Hepatitis C, MRSA.

_____ initials — I acknowledge that if I weigh over of 220lbs (99 kgs.) at the time of my death, my donation will be declined.

_____ initials — I agree that my donation will be declined if Stanford does not receive my body within 12 hours of my death.

_____ initials — I acknowledge that the Stanford Anatomical Gift Program has advised and encouraged me to have an alternative arrangement, should the Program decline my donation at the time of my death.

_____ initials — I agree to inform my next of kin, loved ones and caregivers of my wish to donate to the Stanford Willed Body Program.

_____ initials

I acknowledge that information regarding the utilization of my donation by Stanford is confidential and will not be disclosed to my next of kin or surviving relatives.

_____ initials

I acknowledge that Stanford Faculty, Physicians and Researchers may photograph or videotape my remains for use in education and research at Stanford. These images or footage will not include any identifying features and my anonymity will be maintained.

_____ initials

I understand that Stanford will not provide my family or next of kin with any report of medical findings.

_____ initials

I understand and agree that my donation will be utilized for the purposes of teaching, training, and research, in such manner deemed appropriate by the Stanford Anatomical Gift Program and Stanford School of Medicine.

_____ initials

I understand that Stanford does not guarantee my donation will be used for any specific area of research or educational event related to my diagnosis.

_____ initials

I understand that the Stanford Anatomical Gift Program accepts whole body donation only, which I understand is incompatible with organ donation. Should I undergo organ donation, I understand that I will be ineligible for donation to the Stanford Anatomical Gift Program

I understand and accept that the Stanford Anatomical Gift Program will not return my cremated remains to my next of kin, surviving relatives or any other interested parties.

SIGNATURE DATE

I hereby state that it is my wish to donate my body to Stanford University School of Medicine immediately upon my death, and I agree to all the above listed requirements.

Donor Signature: _____

Date: _____

Power of Attorney Signature (if applicable): _____

Witnesses (2 Required):

We the undersigned, have witnessed the signing of this document by the potential donor.

1. Signature of Witness _____

   Printed Name _____

   Address _____

   City, State, Zip _____

2. Signature of Disinterested Witness* _____

   Printed Name _____

   Address _____

   City, State, Zip _____

*"Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to which an anatomical gift could pass under California Health and Safety Code Section 7150.50

Upon the donor's death, call 650-723-2404 for immediate pickup. We are on-call 24 hours/day every day of the year, and will arrange for a funeral home to take the donor into our care, and transport them to Stanford.