INSTRUMENT OF ANATOMICAL GIFT

CONSENT AND AUTHORIZATION, DISPOSITION AND DECLARATION AS TO REMAINS
FOR AN ANATOMICAL GIFT DONATION BY NEXT OF KIN

1. Consent and Authorization

I, ____________________________________________________________
BEING THE NEXT OF KIN HEREBY OFFER AS AN UNRESTRICTED GIFT THE BODY OF
_________________________________________ AFTER DEATH, FOR EDUCATION AND/OR RESEARCH.

By signing this consent and authorization I intend for TUSM to have the exclusive right to (i) control the use of his/her body for medical/dental education, research, science or therapy; and (ii) authorize the disposition of the body upon death.

I understand that NO AUTOPSY should be performed and NO EMBALMING should be done upon his/her death, however after acceptance of the donation TUSM may embalm and/or perform dissection for the purposes of education and/or research. TUSM will provide transportation WITHIN 24 HOURS OF THE TIME OF DEATH. If a funeral home is contracted to transport from the place of death to the medical school, TUSM will pay the funeral director a stipend for the costs of transportation and for obtaining the necessary permits. I understand that I will be responsible for any costs charged by the funeral director that exceed the TUSM stipend.

I authorize any and all health care providers holding his/her health information at the time of death to release the health information to TUSM for the purpose of implementing the donation. I authorize TUSM to use or disclose his/her health information as reasonably necessary to effectuate the donation or for the purposes of advancing education and/or research or for the disposition of his/her remains (e.g. funeral personnel and others). I understand that once a health care provider or TUSM discloses the health information to a recipient neither the health care provider nor TUSM can guarantee that the recipient will not disclose the health information to a third party.

After acceptance of the gift of his/her body by TUSM, unless otherwise indicated below, TUSM may in its sound judgment and sole discretion allow his/her body to be utilized by another medical or dental school, or another institution or entity (including nonprofit and for-profit entities) for research and/or education. At the conclusion of the use of his/her body by TUSM (or by another, under TUSM's permission as contemplated herein), and except as otherwise provided below, TUSM will be responsible for the disposition of the remains according to my direction below, and I hereby authorize TUSM to arrange cremation of the body. If TUSM cannot carry out my instructions for any reason, I understand that TUSM will arrange for his/her body to be cremated, and I hereby authorize TUSM to arrange for cremation.

2. Disposition

I further direct that, after his/her body is no longer useful for the purposes stated above, TUSM should coordinate the disposition of the remains as I have indicated below (indicate a single choice from the following options by placing a check mark within the brackets to the left of that option):

Page 1 of 4
[ ] CREMATION and return of cremains to next-of-kin or executor listed below by registered U.S. Mail at the expense of TUSM.

The next-of-kin relationship is defined as follows: Persons with authority to make a decision for cremation are listed here in order of priority. The order of priority is as follows: (1) spouse, (2) an adult son or daughter, (3) either parent, (4) an adult brother or sister, (5) a guardian of the person of the decedent at the time of death, (6) any other person authorized or under obligation to dispose of the body. A subsequent class of persons has authority to make the decision only if there is no person occupying the preceding class.

Send cremains to the following address:

(Name)                                                                                          (Street Address or P.O. Box)

(Apt. Number)                                                                                                (Telephone Number)

(Town)                                                                                     (State)                                                                                     (Zip Code)

(Relationship to Donor)                                                                                     

[ ] CREMATION and hold of cremains for pick-up by next-of-kin at a site designated by TUSM. This option can be arranged only with authorization from the Anatomical Gift Program at TUSM.

[ ] Release his/her remains without cremation, to the funeral director/home identified below, for disposition to be arranged by the estate at the expense of the estate. I understand that after use by TUSM or by others as authorized above, his/her remains will not be in a condition suitable for viewing.

Funeral Director                                                                                   Address

Telephone Number

I also understand that his/her remains or cremains will not include tissues that have been removed for medical research or education purposes.

I understand that this is a legal document being signed by me in accordance with the Massachusetts Anatomical Gift Act, M.G.L. ch. 113A §§ 1-25, and the Uniform Anatomical Gift Act.
Having read this instrument in full and understanding its content and effect, and having had the opportunity to ask questions about this authorization, I hereby sign it and, knowingly and voluntarily consent to and authorize the actions described herein, in the presence of the witnesses whose signatures appear on page four (4) of this document:

___ __________________________
Next of Kin (Please Print) Signature

__________________________
Mailing Address

__________________________
City, State Zip Code

Telephone Number

3. Declaration As To Remains

I, __________________________ (Next of Kin), do hereby make, constitute and designate Tufts University School of Medicine’s Health Sciences Anatomical Gift Program located at 136 Harrison Avenue, Boston, Massachusetts 02111, as the legally authorized party to control ______________________ (Donor) bodily remains. Control over his/her remains includes authority to take any and all actions necessary to effectuate the donation of the body in furtherance of medical and dental education, research, science or therapy and the disposition of the remains at the time that his/her body may no longer be used in furtherance of medical and dental education, research, science or therapy. TUSM’s Health Sciences Anatomical Gift Program shall have the power and authority to authorize the cremation or the burial with or without cremation and to sign, seal, execute, acknowledge and deliver any and all documents or instruments of any kind, nature or description required by law or practice as it deems necessary and appropriate in order to effectuate and facilitate the donation and the disposition of his/her remains, including but not limited to, any and all statements, forms or authorizations concerning the donation or disposition and to do all other things necessary or appropriate to accept the donation and accomplish disposition of his/her remains.

WITNESS the execution of this Declaration this ____ day of _________ 20___.

NEXT OF KIN:________________________
Signature:________________________
Name (Printed):____________________
Date:_____________________________

Please check to be certain that you have completed this page above with the information in each of the underlined spaces provided.
WITNESSES’ ATTESTATION

This consent and authorization to donate must be witnessed by two other parties.

TUSM requests that the form be witnessed by one of the donor’s next-of-kin as indicated below and a disinterested witness.

**IMPORTANT:** The order of next-of-kin priority is as follows: (1) current spouse; (2) an adult son or daughter; (3) either parent; (4) an adult brother or sister; (5) an adult grandchild; (6) a grandparent; (7) an adult who exhibited special care and concern; and (8) a guardian of the person of the decedent at the time of death. *Disinterested witness is defined as 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 donor.*

We hereby sign our names as witnesses:

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<thead>
<tr>
<th>Signature of Witness</th>
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<tbody>
<tr>
<td>Name of Witness (Please Print)</td>
<td>Name of Witness (Please Print)</td>
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<td>Address</td>
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<td>Relationship to Donor</td>
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DONOR INFORMATION FORM

To ensure registration in the Anatomical Gift Program at Tufts University School of Medicine, the following information MUST be completed and returned along with your completed Instrument of Anatomical Gift. This information is necessary for the completion of legal documents required at the time of death of a donor.

Donor’s Full Name ___________________________ Male____ Female____

First Middle Last

Legal Address

Street ___________________________ City ___________________________ State Zip Code ___________________________

County of Residence ___________________________ Telephone Number ___________________________

Donor’s Race: White____ Black____ Hispanic____ American Indian____

Date of Birth ________ Place of Birth ___________________________ Social Security Number ___________________________

(City & State or Foreign Country)

Full Name of Father ___________________________ Birthplace of Father ___________________________

(State)

Full Maiden Name of Mother ___________________________ Birthplace of Mother ___________________________

(State)

Marital Status (circle one): Never Married, Married, Widowed, Divorced, State Reg. Domestic Partner

Name of Spouse (if wife, enter maiden name) ___________________________

First Middle Last

Usual Occupation (Prior if Retired) ___________________________ Education ___________________________

(Highest Grade Completed)

Kind of Business or Industry ___________________________

If U.S. War Veteran: Specify War ___________________________ Rank ___________________________

Dates of Service ___________________________ Service Number ___________________________

Organization and Outfit ___________________________

Next of Kin Name ___________________________ (First) (Middle) (Last)

Next of Kin Address ___________________________ (Street) (City/Town) (State) Zip Code ___________________________

Next of Kin Telephone Number ___________________________

Next of Kin Email Address ___________________________

Next of Kin Relationship ___________________________

Disease History: Hepatitis A, B, or C, HIV/AIDS, Tuberculosis, Others (MRSA, etc.) ___________________________

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136 Harrison Avenue, Boston, MA 02111 | TEL: 617.636.0837 | FAX: 617.636.3448