THIS COPY FOR:
[ ] Medical School
[ ] Donor

UNC SCHOOL OF MEDICINE **Body Donation Program**
CB# 7520 UNC, Chapel Hill 27599 Phone (919)966-1134
Fax (919)966-6354

CERTIFICATE FOR BEQUEATHING BODY BY NEXT-OF-KIN

In compliance with the Uniform Anatomical Gift Act of the North Carolina General Statutes please complete:

As next-of-kin*, as defined in N.C.G.S. § 130A-404, I_____
(print name)
hereby donate the unembalmed body of _____ to The University of North Carolina School of Medicine's Body Donation Program for scientific study and research.

Medical Information Release:

I hereby authorize the release of the deceased's _____ Protected Health Information to UNC School of Medicine and its Body Donation Program and the applicable crematory in order that it may facilitate the donation of his/her body and cremation of his/her remains. In addition, I give the Body Donation Program permission to release the deceased's medical information to their faculty, staff, and applicable crematory when needed in order to facilitate the preparation and study of the deceased's remains and cremation.

Disposition of ashes:

Upon completion of studies the remains will be reduced to ashes (cremated) and the ashes will be returned to me.

***Definition of Next-of-Kin:**

North Carolina General Statutes (130A.404) defines next-of kin in this order as: (1) The spouse; (2) An adult child; (3) Either parent; (4) An adult sibling; (5) A guardian of the person of the decedent at the time of the decedent's death; or (6) Any other person authorized or under obligation to dispose of the body.

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Signature:_____Date:_____

Relationship to Donor:_____

Address:_____

City, State, and ZIP:_____Birth Date:_____

SSN____-____-_____

You are strongly encouraged to provide your Social Security Number (SSN) here so that the University can accurately and timely comply with Federal, State and/or local government agency reporting requirements, such as to the North Carolina Vital Records Office and to the Social Security Administration. Submission of your SSN on this form is voluntary, however.

(over)

Signature of (1) Witness | Address (city, state, and Zip)

Signature of (2) Witness | Address (city, state, and Zip)

INSTRUCTIONS

This form should be executed in duplicate. The donor keeps a copy, and the original copy should be sent to:

University of North Carolina School of Medicine
Body Donation Program
CB# 7520
Chapel Hill, School of Medicine
Chapel Hill, North Carolina 27599-7520

At the time of death, notify the University of North Carolina School of Medicine's Body Donation Program to arrange transfer of the body to Chapel Hill, NC. For this purpose, telephone:

Regular working hours:
(Monday through Friday,
8:00am to 5:00pm)

Anatomical Materials Curator
University of North Carolina
School of Medicine's Body
Donation Program
CB# 7520
Chapel Hill, NC 27599-7520
(919 966-1134)

After working hours, weekends, and holidays:

Call (919) 966-1134 and follow the instructions

Body Donation Program
University of North Carolina School of Medicine
CB# 7520
University of North Carolina at Chapel Hill
Chapel Hill, NC 27514
(919) 966-1134, Fax (919) 966-6354

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

In connection with the donation of the body of the donor listed below for medical education purposes, I authorize the Body Donation Program of the University of North Carolina at Chapel Hill School of Medicine to use or disclose the protected health information of

Donor Name:_____Date of Birth:_____/_____/_____

Address:_____City:_____State:____Zip Code _____

Telephone: (___) _____Social Security # (voluntary):_____

UNC HCS Medical Record # (if applicable) _____

to the following classes of individuals or entities: students, faculty and staff of the University of North Carolina School of Medicine, governmental or regulatory agencies, if necessary for public health purposes to report any information about his/her medical status at the time of his/her death, and/or the applicable crematory which will cremate his/her remains.

Information to be disclosed may include: Death certificate or other information relating to the cause of death of the donor, or any information discovered in the course of studying the donor's body. I acknowledge that the data to be released MAY INCLUDE INFORMATION PROTECTED BY LAW. MY SIGNATURE BELOW AUTHORIZES INCLUSION OF INFORMATION PERTAINING TO HIV/AIDS AND OTHER COMMUNICABLE DISEASES. The purpose of the use or disclosure is to facilitate the use of the donor's body for medical education and the cremation of his/her remains.

I understand that:

- I may revoke this Authorization at any time:
  - the revocation will not apply to information that has already been released in response to this Authorization
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Information Management Department.
- I may refuse to sign this Authorization:
  - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire upon the return of the donor's cremated remains to his/her family.

I have read and understand the information in this Authorization form.

Signature of Donor:	
Printed Name:	**Date:**

OR

Signature of Authorized Representative:	
Printed Name:	**Date:**
Authorized Representative's authority to act on the behalf of the donor:	

UNC SCHOOL OF MEDICINE
Body Donation Program
CB# 7520 UNC, Chapel Hill 27599
phone (919)966-1134
fax (919)966-6354

SUPPLEMENTARY INFORMATION ABOUT DONOR

Please include the following information, if possible, with the bequeathal certificate to be returned to the Medical Sciences Teaching Laboratories, School of Medicine, University of North Carolina. This information will be helpful in the completion of the death certificate and will facilitate prompt removal of the body.

NAME: _____ SEX: _____
(last) (first) (middle)

ADDRESS: _____
(street, city, state, and ZIP)

COUNTY_____INSIDE CITY LIMITS? [ ] Yes [ ] No

PHONE NUMBER: (____)_____

Please Provide the Last Four Digits of Your Social Security Number (SSN): _____

[ ] Married [ ] Single
[ ] Widowed [ ] Divorced

Spouse: _____
(wife's maiden name or husband's name)

Date of Birth: _____

Place of Birth: _____
(county and state)

Usual Occupation: _____
(list kind of work done during life, even if retired)

Was donor in the U.S Armed Forces?
[ ] yes [ ] no

Highest grade of education completed: ____
[Elementary/Secondary (0-12) College (13-17+)]

Father's Name and Birthplace: _____

Mother's Maiden Name and Birthplace: _____

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PHYSICIAN: _____
name and address (street, city, state and ZIP)

ATTORNEY: _____ (____)_____
name telephone

_____
address (street, city, state and ZIP)

Donor's will is recorded in the County of: _____ State of: _____

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This information has been provided by:

[ ] Donor [ ] Other: _____ (____)_____
name telephone

_____
address (street, city, state and ZIP)

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