CERTIFICATE OF AUTHORIZATION FOR POST-MORTEM STUDY AND EXAMINATION OR REMOVAL OF TISSUES OR ORGANS

I, the undersigned, this _____ day of _____, 20_____ desiring that my _____ be made available after my demise for:

(1) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(2) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school of mortuary science;

(3) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(4) The donee specified below, for therapy or transplantation needed by him or her, do hereby donate my _____ for said purpose to _____ (name) _____ (address)

I hereby authorize a licensed physician, surgeon or certified technician or the state anatomy board to remove and preserve for use my _____ for said purpose.

_____
(Donor's Signature)

_____
(Donor's Printed Name)

_____
(Donor's Address)

_____

(Donor's Telephone)

_____

(Witness Signature)

_____

(Witness Printed Name)

_____

(Witness Address)

_____

(Witness Telephone)

_____

(Witness Signature)

_____

(Witness Printed Name)

_____

(Witness Address)

_____

(Witness Telephone)