University of Massachusetts
UMASS Medical School

Department of Cell Biology
55 Lake Avenue North
Worcester MA 01655

Anatomical Gift Program
phone 508-856-2460 *fax* 508-856-1033

Thank you for your interest in the University of Massachusetts Medical School's Anatomical Gift Program. Enclosed you will find the forms you requested to register for this program.

Please read through the packet, complete the necessary forms, and return them to this school complete with the ***Table of Contents page intact.*** A pre-addressed envelope has been enclosed for your convenience. Please remove pages 2 & 3 for future reference, and page 12, *Change of Statistical Information*.

If you have any questions please call 508-856-2460.

University of Massachusetts Medical School
Anatomical Gift Program

Donor Registration Packet

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General Instructions

University of Massachusetts Medical School
Anatomical Gift Program
Department of Cell Biology, Room S7-244
55 Lake Avenue North
Worcester MA 01655

All donor application forms must be completed and signed where indicated. Some of the forms will require a signature witnessed by two people. Please keep the packet intact except for the second, third and last pages which you will remove and keep for your reference or if there are changes. Mail the completed forms to the University of Massachusetts Medical School, Anatomical Gift Program in the envelope provided or to the address noted above.

Once the forms have been reviewed and accepted, an acknowledgement will be sent along with a donor identification card. A letter of instruction will be mailed to the donor's appointed next of kin.

Please feel welcome to call the Anatomical Gift Program at 508-856-2460 if you have any questions. All information provided will remain confidential to the extent allowed by law.

Instrument of Anatomical Gift
Please complete both pages of this form in front of two witnesses. This form will indicate the designation of remains after the completion of studies. If the donation is made by the attorney-in-fact under a valid durable power of attorney that expressly authorizes the attorney-in-fact to make an anatomical gift of the principal's body, a complete legible copy of the durable power of attorney must accompany this form.

Donor Information Sheet
Complete the data sheet with accuracy. The information you provide will be used for completing and processing the death certificate with the Health Department and the Commonwealth. Death certificates are filed in the town hall or city hall of the town where death occurs. A certified death certificate may be obtained by making arrangements with the respective town hall or city hall office.

Worksheet for Medical and Social History
Complete this data sheet with as much detail as possible. The information provided is of great value to teaching and research.

Privacy Act Notification and HIPAA
Provided as required by the state and federal law.

Change of Statistical Information
To be returned to this office to report changes such as: donor's address and telephone number; designated next of kin's address and telephone number; and change in marital status.

HIPAA and Privacy Act Notification
Organ Donation

HIPAA

The Department of Health and Human Services (HHS) issued the Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide the first comprehensive federal protection for the privacy of personal health information.

Under HIPAA, we need authorization to obtain medical record information from the health care provider at the time of death of a UMass donor. It is the responsibility of the donor's next of kin to authorize the release form with the necessary provider; i.e. hospital, nursing home, hospice facility. The principal purpose for the health information is to obtain information necessary to determine acceptance of a body for the UMMS Anatomical Gift Program at the time of death of a donor

Privacy Act Notification

The Privacy Rule permits covered entities to disclose PHI (Protected Health Information), without authorization, to public health authorities or other entities that are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury and reporting vital event records, such as births and deaths (Reference 45 Code of Federal Regulations (CFR) Section 164.512). Please refer to page 2, General Instructions.

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. Disclosure of the social security number is required pursuant to the regulations of the State Registrar of Vital Statistics. The social security number is used to verify your identity and to provide information necessary for filing a death certificate

Organ Donation

Organ donation is different from anatomical donation. If one donates one's organs, one cannot donate a body to the University of MA Medical School. If a person has noted 'organ' donation on his or her license and then decides to donate to the Anatomical Gift Program, it is advised to have the organ donation status changed with the Registry of Motor Vehicles as well as with the New England Organ Bank.

Next of Kin or Executor

The person responsible for making arrangements should call the University of Massachusetts Medical School's Anatomical Gift Program at 508-856-2460 to determine if the Medical School can accept the donation. If the University of Massachusetts Medical School accepts the donation, the School will arrange for the transportation from the place of death within Massachusetts to the University of Massachusetts Medical School. A cost may be incurred to the donor's estate if a body is transported from out of state. **THE MEDICAL SCHOOL RESERVES THE RIGHT TO DECLINE ANY PARTICULAR GIFT.** The body must be delivered to the School WITHIN 24 HOURS of death unless other arrangements are made with the Medical School.

Instrument of Anatomical Gift

Pursuant to the provisions of the Uniform Anatomical Gift Act, Chapter 23-06.2 and Massachusetts General Laws, Chapter 75, s. 36A, and Chapter 113, ss. 7-13

I, _____
Name of Donor (please type or print clearly)

Being of sound mind and over the age of eighteen (18) years, do hereby, effective at the time of my death, give my entire body to the University of Massachusetts Medical School for the purposes of education, research, and advancement of science pursuant to this agreement. **The University of Massachusetts Medical School reserves the right to decline donations depending on the condition of the body at the time of death and/or the needs of the institution**. Alternative arrangements will be required in the event that the gift cannot be accepted.

Cremation Policy

As of January 1984, the University of Massachusetts Medical School will accept Instrument of Anatomical Gift forms ONLY from those donors who agree to cremation or release of remains for private burial. Burial of cremated remains (ashes) at Pine Hill Cemetery will also be available for donors to this school.

I FURTHER DIRECT THAT, AFTER STUDIES ARE COMPLETE, THE DESIGNATED SCHOOL SHALL:

____ Cremate my body and release my CREMAINS to my executor or next of kin for private burial at the expense of my estate.

____ Does not cremate my body and releases my remains to my executor or next of kin for private burial at the expense of my estate.

____ As a donor to the University of Massachusetts Medical School, I do agree to be cremated. Please bury my cremains at the expense of the medical school in the Pine Hill Cemetery in Tewksbury, Massachusetts, in a registered grave.

_____
Signed

Instrument of Anatomical Gift

Having read the Instrument of Anatomical Gift for the University of Massachusetts Medical School in full and understanding its content and legal effect, I hereby sign it in the presence of the undersigned witnesses:

Name of Donor (Please Print) _____ Signature of Donor _____

Address _____ Social Security Number _____ Date of Birth _____

City _____ State _____ Zip Code _____ Date _____

WITNESS ATTESTATION
Signed in our presence and we hereby subscribe our names as witnesses:

1)

Signature of Witness _____

Name of Witness (Please Print) _____

Address _____

City _____ State _____ Zip Code _____

Date _____

2)

Signature of Witness _____

Name of Witness (Please Print) _____

Address _____

City _____ State _____ Zip Code _____

Date _____

ADDITIONAL INFORMATION
NEXT OF KIN OR EXECUTOR

Name (Please Print) _____ Relationship to Donor _____

Address _____ Telephone Number _____

City _____ State _____ Zip Code _____ Alternative Telephone Number _____

Donor Information Sheet

In addition to the information on the Instrument of Anatomical Gift form, the following information is necessary for the completion of legal documents required at the time of death of a donor. Please complete and return this form with your completed Instrument of Anatomical Gift.

Donor's Full Name (First, Middle, Last): _____

E-Mail Address: _____

Donor's Legal Address: _____
(Street and number, city, state, zip code)

Donor's Telephone Number: _____

Donor's Race: White _____ **Black** _____ **Hispanic** _____ **American Indian** _____
Other (please specify) _____

Donor's Date of Birth: _____ **Soc. Sec. No.** _____

Donor's Place of Birth: _____

Donor's Marital Status: Married _____ **Never Married** _____ **Widowed** _____ **Divorced** _____

Spouse's MAIDEN Name: _____
*(if applicable to female, otherwise list **husband's full name; applies to widowed and/or divorced as well**)*

Donor's Occupation: _____
(*if retired – previous occupation must be listed)*

Donor's Education:
(Highest grade completed) **Grades 1-12** _____ **College 1-4, 5+** _____

If U.S. War Veteran: Specify War: _____ **Rank:** _____

Dates of Service: _____ **Service Number:** _____

Donor's Father's Name: _____
Donor's Father's Place of Birth: _____

Donor's Mother's MAIDEN Name: _____
Donor's Mother's Place of Birth: _____

NOTE: Please be sure to write the MAIDEN name of spouse and of mother when applicable. This information is required when filing for a death certificate.

Worksheet for Medical and Social History

DONOR NAME	DATE OF BIRTH
OCCUPATION **PREVIOUSLY IF RETIRED**	RETIRED PLEASE CHECK ONE ☐ YES ☐ NO

NOTE! ALL QUESTIONS WITH "YES" OR "OTHER" RESPONSES MUST INCLUDE AN EXPLANATION OF THE ANSWER. PLEASE USE THE SPACE TO THE RIGHT TO PROVIDE ADDITIONAL INFORMATION.

HAS THE DONOR HAD ANY OF THE FOLLOWING:

1. SEPTICEMIA ☐ YES ☐ NO ☐ OTHER	
2. SYSTEMIC BACTERIAL INFECTION ☐ YES ☐ NO ☐ OTHER	
3. VIRAL OR FUNGAL INFECTION ☐ YES ☐ NO ☐ OTHER	
4. CONNECTIVE TISSUE DISEASE ☐ YES ☐ NO ☐ OTHER	
5. AUTO IMMUNE DISEASE ☐ YES ☐ NO ☐ OTHER	
6. RHEUMATOID ARTHRITIS ☐ YES ☐ NO ☐ OTHER	
7. SYSTEMIC LUPUS ☐ YES ☐ NO ☐ OTHER	
8. ERYTHEMATOSIS ☐ YES ☐ NO ☐ OTHER	
9. CANCER ☐ YES ☐ NO ☐ OTHER	
10. LYMPHOMA ☐ YES ☐ NO ☐ OTHER	
11. LEUKEMIA ☐ YES ☐ NO ☐ OTHER	
12. SARCOMA ☐ YES ☐ NO ☐ OTHER	
13. MELANOMA ☐ YES ☐ NO ☐ OTHER	
14. THERAPEUTIC IRRADIATION ☐ YES ☐ NO ☐ OTHER	

15. CHEMOTHERAPY ☐ YES ☐ NO ☐ OTHER	
16. EXPOSURE TO: a. CYANIDE b. LEAD/MERCURY c. PESTICIDES d. AGENT ORANGE	☐ YES ☐ NO ☐ OTHER ☐ YES ☐ NO ☐ OTHER ☐ YES ☐ NO ☐ OTHER ☐ YES ☐ NO ☐ OTHER
17. DIABETES, INSULIN OR NON-INSULIN – HOW LONG? ☐ YES ☐ NO ☐ OTHER	
18. ALZHEIMER'S ☐ YES ☐ NO ☐ OTHER	
19. PARKINSON'S ☐ YES ☐ NO ☐ OTHER	
20. CREUTZFELDT-JAKOB ☐ YES ☐ NO ☐ OTHER	
21. MULTIPLE SCLEROSIS ☐ YES ☐ NO ☐ OTHER	
22. BRAIN TUMOR ☐ YES ☐ NO ☐ OTHER	
23. SEIZURES ☐ YES ☐ NO ☐ OTHER	
24. CONFUSION/MEMORY LOSS ☐ YES ☐ NO ☐ OTHER	
25. FAMILY HISTORY OF NEUROLOGICAL DISEASE ☐ YES ☐ NO ☐ OTHER	
26. HEART DISEASE ☐ YES ☐ NO ☐ OTHER	
27. RHEUMATIC FEVER ☐ YES ☐ NO ☐ OTHER	
28. VALVULAR DISEASE ☐ YES ☐ NO ☐ OTHER	
29. ENDOCARDITIS ☐ YES ☐ NO ☐ OTHER	
30. MIGRAINES ☐ YES ☐ NO ☐ OTHER	
31. PREVIOUS MYOCARDIAL INFARCTION ☐ YES ☐ NO ☐ OTHER	
32. HIGH BLOOD PRESSURE ☐ YES ☐ NO ☐ OTHER	
33. CHEST PAIN ☐ YES ☐ NO ☐ OTHER	
34. LUNG DISEASE ☐ YES ☐ NO ☐ OTHER	

35. ASTHMA ☐ YES ☐ NO ☐ OTHER	
36. EMPHYSEMA ☐ YES ☐ NO ☐ OTHER	
37. TESTED POSITIVE FOR OR TREATED FOR TUBERCULOSIS ☐ YES ☐ NO ☐ OTHER	
38. KIDNEY DISEASE ☐ YES ☐ NO ☐ OTHER	
39. KIDNEY/GALL STONES ☐ YES ☐ NO ☐ OTHER	
40. REQUENT/RECURRENT INFECTIONS ☐ YES ☐ NO ☐ OTHER	
41. REQUIRED DIALYSIS ☐ YES ☐ NO ☐ OTHER	
42. LIVER DISEASE ☐ YES ☐ NO ☐ OTHER	
43. CIRRHOSIS ☐ YES ☐ NO ☐ OTHER	
44. HEPATITIS A, B, C ☐ YES ☐ NO ☐ OTHER	
45. DIGESTIVE OR INTESTINAL PROBLEMS ☐ YES ☐ NO ☐ OTHER	
46. CHRONIC INDIGESTION ☐ YES ☐ NO ☐ OTHER	
47. ULCERS ☐ YES ☐ NO ☐ OTHER	
48. BLOODY STOOLS ☐ YES ☐ NO ☐ OTHER	
49. BROKEN BONES ☐ YES ☐ NO ☐ OTHER	
50. STIFF OR PAINFUL JOINTS ☐ YES ☐ NO ☐ OTHER	
51. HAVE HAD AN ORGAN OR TISSUE TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
52. CORNEA TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
53. BONE TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
54. SKIN TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
55. HEART TRANSPLANT ☐ YES ☐ NO ☐ OTHER	

56. KIDNEY TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
57. DURA MATER TRANSPLANT ☐ YES ☐ NO ☐ OTHER	
58. RECEIVED BLOOD/BLOOD PRODUCTS ☐ YES ☐ NO ☐ OTHER	
59. TRANSFUSIONS – TYPE AND AMOUNT ☐ YES ☐ NO ☐ OTHER	
60. BEEN REJECTED TO DONATE BLOOD – WHY? ☐ YES ☐ NO ☐ OTHER	
61. IMMUNIZED FOR: a. FLU b. TETANUS c. HEPATITIS B	☐ YES ☐ NO ☐ OTHER ☐ YES ☐ NO ☐ OTHER ☐ YES ☐ NO ☐ OTHER
62. BEEN ON PRESCRIPTION MEDICATION/OTC MEDS ☐ YES ☐ NO ☐ OTHER	WHAT TYPE/HOW LONG?
63. TREATED WITH CORTICOSTEROID THERAPY ☐ YES ☐ NO ☐ OTHER	
64. SMOKE TOBACCO PRODUCTS	WHAT TYPE/HOW OFTEN/HOW LONG?
65. DRINK ALCOHOL	WHAT TYPE/HOW OFTEN/HOW LONG?
66. USED ILLEGAL DRUGS OR SUBSTANCES ☐ YES ☐ NO ☐ OTHER	WHAT TYPE/HOW OFTEN/HOW LONG?
67. BEEN TO OR TRAVELED DEEMED MALARIAL W/IN 3 YEARS ☐ YES ☐ NO ☐ OTHER	WHEN/WHERE/HOW LONG?
68. HAVE EYE DISEASE ☐ YES ☐ NO ☐ OTHER	PLEASE DESCRIBE: GLAUCOMA, CATARACTS, ETC.
69. BEEN HOSPITALIZED OR HAD SURGERY ☐ YES ☐ NO ☐ OTHER	WHEN/WHAT TYPE SURGERY?
70. TREATED FOR SEXUALLY TRANSMITTED DISEASE ☐ YES ☐ NO ☐ OTHER	
71. EXHIBIT SYMPTOMS OF UNEXPLAINED WEIGHT LOSS ☐ YES ☐ NO ☐ OTHER	
72. BEEN SCREENED FOR ANTIBODIES AND RESULTS ☐ YES ☐ NO ☐ OTHER	PLEASE INDICATE HIV, JAUNDICE, HEPATITIS B OR C
73. INJECTED DRUGS OR SHARED NEEDLES FOR NON-MED ☐ YES ☐ NO ☐ OTHER	
74. HAVE RECEIVED ANY OF THE FOLLOWING TATTOOS, ACUPUNCTURE, EAR OR BODY PIERCING	☐ YES ☐ NO ☐ OTHER
75. HAVE BEEN CONFINED TO A CORRECTIONAL FACILITY ☐ YES ☐ NO ☐ OTHER	WHEN AND DURATION
76. HAVE RECEIVED BLOOD ☐ YES ☐ NO ☐ OTHER	

77. HAD SEX WITH A PERSON WHO IS KNOWN/SUSPECTED TO HAVE HIV 1, HIV 2, HEPATITIS B OR HEPATITIS C	☐ YES ☐ NO ☐ OTHER
78. DO YOU CONSIDER YOURSELF TO BE A SAFE DONOR ☐ YES ☐ NO ☐ OTHER	

PLEASE INDICATE YOUR PRIMARY CARE PHYSICIAN'S NAME AND PHONE NUMBER

NAME_____PHONE_____

PLEASE INDICATE YOUR CURRENT HEIGHT AND WEIGHT

HEIGHT _____FEET _____ INCHES WEIGHT _____ POUNDS

PLEASE DESCRIBE BELOW, IN YOUR OWN WORDS, WHAT BEING A BODY DONOR MEANS TO YOU. ALL CORRESPONDENCE IS HELD IN THE STRICTEST CONFIDENCE AND WILL BE SHARED ONLY WITH FACULTY AND MEDICAL STUDENTS UNLESS OTHERWISE AUTHORIZED BY DONOR. THANK YOU.

SIGNATURE DATE

Change of Statistical Information
(Donor keeps this page for changes)

To report a change of address, marital status or other pertinent information, please complete this form and mail it to the **University of Massachusetts Medical School Anatomical Gift Program.** Accuracy in your reporting changes helps ensure that data will be recorded correctly.

The Donor's name: _____

❑ Change in Donor's address:

Former Street: _____

City/State/Zip: _____ Phone: _____

Current Street: _____

City/State/Zip: _____ Phone: _____

❑ Change in Marital Status:

❑ Widowed ❑ Married ❑ Divorced ❑ Re-married ❑ Registered Domestic Partner

❑ Change in Name: _____

❑ Other: _____

_____

_____

_____

_____

Mail to: **University of Massachusetts Medical School**
Anatomical Gift Program
Department of Cell Biology
55 Lake Avenue North
Worcester MA 01655

***Or* you may phone: 508-856-2460**