

ANATOMICAL GIFT DONOR FORM

With my signature below, I acknowledge my support to the Anatomical Gift Program in the Department of Physical Therapy at the University of Delaware. It is my intent that at the time of my death, my remains will be donated to the Anatomical Gift Program to be used for anatomical education by students at the University of Delaware. I fully understand the nature of the education related to my anatomical gift, and consent to all necessary, standard, and accepted procedures to conduct said activities.

DONOR INFORMATION:

NEXT OF KIN:

Full name (please print)

Full name (please print)

Date of birth

Relation to donor

Street address

Street address

City, State and Zip Code

City, State and Zip Code

Phone

Phone

Email address

Email address

Signature

Date

Signature

Date

Funeral Home you have chosen (Name, Address, and Phone Number):

If no Funeral Home preference is indicated, Chandler Funeral Homes will be used.

I certify that by signing this document I do not have an extremity amputation or any infectious diseases such as HIV, Hepatitis, Herpes, Prion Disease, Tuberculosis, etc.

Upon completion of the anatomical education, all remains will be cremated. Would you like the cremated remains to be returned to the family?

Yes _____ No _____

Please return form to: University of Delaware-Department of Physical Therapy, Attn: Anatomical Donor Program, STAR Health Sciences Complex, 540 S. College Avenue, Suite 210, Newark, DE 19713