

**Anatomical Gift Form**

**WSU Health Sciences Spokane  
Willed Body Program  
ESFCOM, HSB 320Q  
PO Box 1495  
Spokane, WA 99210-1495**

I agree that, upon my death, I wish my body to be offered to the **Washington State University Willed Body Program**, to be preserved and used in such a manner as the University deems desirable for educational and scientific purposes.

I agree that the University may loan my body or any of its parts to other institutions for purposes of medical teaching and research. Upon completion of use (four years maximum), my body shall be cremated and the cremated remains will be interred at the Greenwood Cemetery in Palouse, Washington, or returned to the family if desired.

I agree that the University may keep any of my body parts indefinitely for continuing teaching or research purposes.

I agree that the University reserves the right to decline my body donation for any reason. The acceptance or declining of a body donation is made at the time of death. I am aware that alternate arrangements should be made in the event my body donation is declined.

I agree to inform my family and physician of my decision to donate my body to the Washington State University Willed Body Program.

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**AUTHORIZATION**

I wish to give my body to the Washington State University Willed Body Program immediately after my death to be preserved and used by the University for medical teaching and research.

Print Full Name \_\_\_\_\_ Date \_\_\_\_\_

Donor Signature \_\_\_\_\_

**REQUIRED: Two witness signatures** (Can be a family member or a friend)

Witness 1: \_\_\_\_\_ Date \_\_\_\_\_

Witness 2: \_\_\_\_\_ Date \_\_\_\_\_

Complete this form, sign, date, and return the **original copy** to Washington State University at the address above. Before mailing this form make copies for your records, your family, and your physician.

# Final Interment Form

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PO Box 1495  
Spokane, WA 99210-1495

Donor Name \_\_\_\_\_

Select one of the two options below for the final disposition of the cremated remains by checking the appropriate box. If you select Option 2, please provide the information requested for the legal next of kin.

**Option 1**

- **Bury my cremated remains at the Washington State University Willed Body Program burial site at Greenwood Cemetery, Palouse, Washington.** There is no cost to the donor's estate for Option 1.
- This is a Willed Body Program community gravesite marked by a plaque with the inscription "In dedication to those who have donated their remains for the advancement of medical science and education."
- If you wish to have your name, date of birth and date of death engraved in the memorial stone, contact Mark Kramer at Kramer's Funeral Home in Palouse, Washington, (509-878-1221) to make the arrangements. This engraving service is provided at the expense of the family.

**Option 2**

- **Return my cremated remains to the residence of my legal next of kin for private burial by the family** (unless instructed differently by your legal next of kin, i.e. spouse, son, daughter, etc.) after your death. Your family will be notified by mail or phone before the cremated remains are sent. The cost of transporting your cremated remains is paid for by the Washington State University Willed Body Program if the destination is within the United States or Canada.
- The final resting place of the cremated remains is determined and paid for by the donor's family or estate.

*Print* Name of Legal Next of Kin \_\_\_\_\_

*Sign* Name of Legal Next of Kin \_\_\_\_\_

Phone number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Donor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Medical History Form**

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Spokane, WA 99210-1495**

Donor's name \_\_\_\_\_

Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Current health problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the following, please list the month and year of any organ removal, transplants, pacemaker, deformities, amputations, etc.

Past health problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgical history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a pacemaker? Yes \_\_\_\_\_ No \_\_\_\_\_

Today's date \_\_\_\_\_

## Personal and Contact Information Form

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Spokane, WA 99210-1495**

Full name of donor (print) \_\_\_\_\_

Date \_\_\_\_\_ Phone number \_\_\_\_\_

Email address \_\_\_\_\_

Current address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County of residence \_\_\_\_\_ Within city limits: Yes  No

Length of time at current residence \_\_\_\_\_ U.S. citizen: Yes  No

Date of birth \_\_\_\_\_ Male  Female   
*Month Day Year*

Place of birth \_\_\_\_\_  
*City County State*

Social Security Number \_\_\_\_\_ U.S. Veteran: Yes  No

Marital status: Single  Married  Widowed  Divorced

Surviving spouse's name (wife's maiden name) \_\_\_\_\_  
*First Middle Last*

Primary occupation \_\_\_\_\_

Type of business/industry \_\_\_\_\_

Highest level of education/degree \_\_\_\_\_

Ethnicity: White  Black  Asian  Hispanic  Native American  Other \_\_\_\_\_

Donor's father's name \_\_\_\_\_  
*First Middle Last*

Donor's mother's maiden name \_\_\_\_\_  
*First Middle Last*

### **Next of Kin/Executor of Estate Contact Information**

Name \_\_\_\_\_

Relationship to donor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number(s) \_\_\_\_\_

Email address \_\_\_\_\_

### **Alternate Contact Information**

Name \_\_\_\_\_

Relationship to donor \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number(s) \_\_\_\_\_

Email address \_\_\_\_\_

- Please mail all original forms to:  
**Washington State University**  
**ESFCOM, HSB 320Q**  
**Willed Body Program**  
**PO Box 1495, Spokane, WA 99210-1495**
  
- Make photocopies for your records, your family, and your physician
- If you have additional questions, please call 509-368-6600