Anatomical Gift Association of Illinois

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DONOR ENROLLMENT FORM – PLEASE RETAIN A COPY

_____	XXXX-XX-_____
NAME OF DONOR – PLEASE PRINT OR TYPE	SOCIAL SECURITY NUMBER (last four digits only)
_____	_____
Street Address	Email Address
_____	_____
City, State, ZIP Code	Telephone

Being of sound mind and disposition I do hereby stipulate that the remains of the above named, upon death, be used in whatever manner deemed necessary and appropriate by the Anatomical Gift Association of Illinois (AGA). I understand that such use may involve display of anatomical structures for educational, research, and training purposes.

I understand that the next of kin or executor must arrange to have the unembalmed remains transferred to the AGA by a licensed funeral director immediately after death. The expense of the transportation, death certificate, and cremation permit, as determined by the funeral home of your choice, is the responsibility of the donor's family or estate. I also understand that the AGA reserves the right to decline the gift if, in its opinion, the gift is not suitable for donation for any reason. In the event of refusal of remains, I understand that the next of kin, executor, or other responsible individual assumes responsibility for making alternative arrangements.

The AGA will receive, prepare, preserve and distribute the remains. I authorize the release of medical information concerning the donor to the extent it is known. I am aware that donations may be used for three years or more and that no formal report or results from study will be released. I hereby certify that no other relative or party in interest has objected to this donation. I further understand that at any time prior to death one may revoke intended donation by written communication to the AGA. I acknowledge that in reviewing and signing this document I have had the opportunity to review it with someone I trust.

_____ _____

Signature of Donor or Responsible Party Date

Please select ONE option below to determine the final disposition of the intended donation:

◉ 1. Return Ashes - I request that ashes be returned to the address specified below at the expense of the AGA. Cremation shall occur upon conclusion of medical/scientific study, which may be three years or more. Please return ashes to:

_____, whose address is, _____

_____ and phone, _____.

○ 2. No Ashes - Ashes will **NOT** be returned and will be interred in accordance with the laws of Illinois.

○ 3. Perpetual Donation - Part or all of my body may be retained or permanently preserved for teaching and related purposes. I understand that part or all of my remains may be cremated and any ashes will **NOT** be returned. The AGA will provide no information on final disposition.

Please indicate a preferred Institution for the study of the remains, if any: _____

FIRST WITNESS –Name and relationship to donor (Please print):	SECOND WITNESS –Name and relationship to donor (Please print):
Street Address:	Street Address:
City, State, and ZIP Code:	City, State, and ZIP Code:
Signature and Date:	Signature and Date:

August 1, 2020

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