

# DONOR REGISTRATION FORM

## Willed Body Program

University of Washington School of Medicine  
Department of Biological Structure  
Box 357420, Seattle WA 98195-7420

Telephone: 206-543-1860, (Alternate number 206-598-3300)

- I agree that the University may use my body and any of its parts, including body fluids, tissues and organs, for the development of one or more research, diagnostic, or therapeutic product or procedure.
- I agree that the University may loan my body or any of its parts to other institutions for purposes of medical or surgical teaching and research.
- I agree to cremation of my remains as a condition of donation. If I want my available cremated remains returned to my family I must check the box and initial in the space provided for this purpose at the bottom of this Donor Registration Form. The available cremated remains exclude any of my body parts retained for continuing teaching or research. If I do not choose to have my cremated remains returned to my family, they will be buried at the University burial site at the Evergreen-Washelli Cemetery in Seattle, Washington during an annual nondenominational burial service. **Cremated remains will not be recoverable after burial.**
- I agree that the University may keep any of my body parts for continuing teaching or research purposes. Body parts that the University keeps will be cremated after they are used and will be buried at the University burial site at the Evergreen-Washelli Cemetery in Seattle, Washington during an annual nondenominational burial service. These cremated remains will not be returned to my family.
- I agree that the University may decline to accept my body for any reason.
- I agree to inform my family and physician of my decision to give my body to the University of Washington.
- I have read and understood the Donor Information Letter. I have had the opportunity to ask the Willed Body Program any questions I have, and I have had my questions answered before signing this form.
- I agree that the specific details of how my remains have been used are confidential and will not be disclosed to my family after my death, unless provided for by law.

### AUTHORIZATION

I wish to give my body to the University of Washington School of Medicine immediately after death to be preserved and used by the University for medical or surgical teaching and research.

**Your signature below implies that you have read and are in agreement with the statements written above. (References to "the University" refer to the University of Washington).**

**\*NOTE:** If the donor is medically unable to sign his/her own name to this registration form, the legal next of kin should call the Willed Body Program Office prior to mailing in this form. (Call 206-543-1860). (Alternate phone: 206-598-3300.)

Print Full Name (LAST) (FIRST) (MIDDLE) (Salutation: Mr., Mrs., Ms.)	Last four (4) digits of Social Security No. _____
* Donor Signature (See "NOTE" above) _____ Date _____	Date of Birth _____
Complete Address (STREET) Apt. # _____	
(CITY) (STATE) (ZIP)	Phone Number _____

**It is required that you respond to one of the following two questions. (Check only one box)**

Option 1: <input type="checkbox"/> Bury my cremated remains in the common University Burial site at Evergreen-Washelli Cemetery.	<input type="checkbox"/>
Option 2: <input type="checkbox"/> Return my cremated remains to my legal next of kin for disposition.	<input type="checkbox"/>

**WITNESSES**

**It is required that you provide the signatures of two witnesses. A witness can be a family member or a friend. Each witness should print his/her name, enter the date and then sign name.**

**Witness 1:**

Print Name	Date
Sign Name	

**Witness 2:**

Print Name	Date
Sign Name	

**Provide information of your spouse or other family member(s) and the personal representative of your estate if applicable in the spaces provided below.**

Print Name	Relation to you	Date
Address		Phone No. (include Area Code)
(CITY)	(STATE)	(ZIP)
(COUNTY)		Alternative Phone No. (include Area Code)

Print Name	Relation to you	Date
Address		Phone No. (include Area Code)
(CITY)	(STATE)	(ZIP)
(COUNTY)		Alternative Phone No. (include Area Code)

**IF YOU HAVE QUESTIONS:** Please contact Mavis Carpio Montgomery, Program Operations Manager at 206-543-1860.

Be sure to complete this form **entirely**. Sign, date, and return the original in the enclosed prepaid envelope. Incomplete forms could delay your registration.

**MAILING ADDRESS**  
 University of Washington School of Medicine  
 Willard Body Program  
 Department of Biological Structure  
 Box 357420  
 Seattle, WA 98195-7420

**NOTE:** Before mailing this original you may want to make copies for your personal records, your family, physician and all other persons that may be handling matters after your death.