



Donor's Consent for Anatomical Donation to the Anatomical Donation Program of the Hackensack Meridian School of Medicine – Registry Enrollment

To be completed by the prospective donor

Hackensack Meridian School of Medicine
Anatomical Donation Program
123 Metro Boulevard, Nutley, NJ 07110
Phone: 551-497-1375
Email: adp@hmsom.edu | Website: HMSOM.edu/adp

1. **Permission and Authorization.** I, [_____ insert name, address _____], being of sound mind and at least 18 years of age, by signing this Donor's Consent for Anatomical Donation, authorize and direct that immediately upon my death, my whole body shall be donated to the Anatomical Donation Program of the Hackensack Meridian School of Medicine, a New Jersey Nonprofit Corporation, located at 123 Metro Blvd., Nutley, NJ 07110 ("HMSOM Anatomical Donation Program") for the purposes of anatomical research or education.
2. **Donor Registry.** My consent to donate my body after death is to be recorded on the HMSOM Donor Registry.
3. **HMSOM Anatomical Donation Program Documentation.** I have read the HMSOM Anatomical Donation Program Documentation at HMSOM.edu/adp ("Program Documentation"). I agree to abide by all of the requirements, policies and procedures of the HMSOM Anatomical Donation Program and further give permission for my body to be utilized in accordance with the Program Documentation, including but not limited to the following:
 - a. **Embalming.** I authorize and give my permission for the embalming of my donated body.
 - b. I understand and accept that anatomical research or education studies generally take between one (1) and three (3) years, and some donations or portions of donations may be kept for longer periods of time for those purposes.
4. **Notice.** If possible, prior to my death, but not later than 24 hours following my death, my authorized representative will notify the HMSOM Anatomical Donation Program at 551-497-1375 or adp@hmsom.edu of my anticipated death or actual death.
5. **Transfer of Donated Body.** At the discretion of the director of the HMSOM Anatomical Donation Program, I authorize the transfer of my body, if it contributes to the Mission of the Program, to another institution authorized to receive anatomical donations.
6. **Transportation of My Body.** I understand that the State of New Jersey is the designated donation area under the HMSOM Anatomical Donation Program. If my death occurs in New Jersey, the HMSOM Anatomical Donation Program is hereby authorized to transport my body in accordance with their policies and procedures. Within New Jersey, there will be no cost to my authorized representative/family members related to transportation expenses of my body. Should my death occur outside of New Jersey, I authorize and direct that in accordance with the policies of the Anatomical Donation Program of HMSOM :

Check ONE of the following two statements:

- (i) I authorize that my body may be donated to a medical school with an anatomical donation program that is located close to the location of my death, and my authorized representative/family members are authorized to pay full transportation costs.
- (ii) My body will be transported to the HMSOM and authorized representative/family members are authorized to pay the full transportation costs.

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7. **Return of My Ashes.** I understand that there are certain circumstances under which anatomical donations may not be accepted as described in the Program Documentation. I acknowledge that in case my body is not accepted by the HMSOM Anatomical Donation Program, it is the responsibility of my authorized representative/family members to make alternative arrangements for the disposition of my body, including payment of the costs. If my body is accepted to the HMSOM Anatomical Donation Program, I authorize and direct that:

Check ONE of the following two statements:

(i) My ashes will be returned to the person listed below, who will assume responsibility for disposition.

Name of prospective donor: _____

Person to whom the decedent's ashes are to be sent:

Name: _____ Relationship to Donor: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail Address: _____

(ii) My ashes will be scattered in accordance with standard protocols.

Certification and Signature:

I certify that I have read and understand the terms and conditions of this Donor's Consent for Anatomical Donation, together with the HMSOM Anatomical Donation Program Documentation. I understand and agree to all of the terms and conditions and have voluntarily signed this form of my own free will with no inducement to do so, financial or otherwise.

Printed Name of Donor: _____

Signature of Donor: _____ Date: _____

In the event I am unable to sign this Donor Consent for Anatomical Donation form, I hereby direct another individual to sign on my behalf in the presence of two (2) witnesses, one (1) of whom must be disinterested.

Name of Donor: _____

Printed Name of Individual signing on behalf of Donor: _____

Signature of Individual signing on behalf of Donor: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Two Witnesses (only necessary if donor is unable to sign and directing another individual to sign on their behalf)

Printed Name of Witness #1: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Signature of Witness #1: _____ Date: _____

Printed Name of Witness #2: _____

Relationship to Donor (must be disinterested): _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Signature of Witness #2: _____ Date: _____