ANATOMY DONOR CONSENT FORM

To whom it may concern:

It is my wish that my remains after death be made available to the holder of a licence under the Anatomy Act 1977 and the Human Tissue Act 1983 at the School of Medical Sciences,

University: _____
(Leave this blank if you do not know your local university).

I consent to the anatomical examination of my body after my death and to the removal of tissue from my body for the purposes of its use for medical or scientific purposes. After completion of anatomical examination and removal of any tissue it is my wish that my body be cremated or buried according to the preferences listed below. I understand that circumstances may make it impossible for the University to accept my offer at the time of my death.

Full Name (BLOCK capitals): _____

Title (Mr / Mrs / Ms / Miss / Dr): _____

Sex (Male / Female):

Marital status: _____

Address: _____
(Please notify the Bequeathal Program, School of Medical Sciences of any change of address)

Date of Birth: _____

Phone Numbers: _____

Name, address and relationship of nearest relation:

_____

_____

Phone Number: _____

Preference as to disposal of remains - please tick your choice:

a) Cremation and the subsequent disposal (scattering) of the ashes in the Crematorium Gardens

b) Cremation and the ashes sent by registered post to:

_____

c) A simple burial. Please note that any additional costs, over those for cremation, would need to be met by your family

The following information is required in order that death may be registered with the Registrar General's Department:

Occupation or Profession (former occupation if retired): _____

Father's full name: _____

Mother's full name and maiden surname: _____

Town and country in which you were born: _____

If born overseas, what year did you first arrive in Australia: _____

If married, where: _____

at what age: _____

to whom: _____

(if female - maiden family name): _____

Children (living & deceased), names and dates of birth:

_____

_____

_____

If married a second time, where: _____

at what age: _____

to whom: _____

Children (living and deceased), names and dates of birth:

_____

_____

_____

If more than 2 marriages please attach details on a separate sheet.

Have you spent six months or more within the United Kingdom between the years 1980 to 1996 inclusively?
(Yes / No)

Have you received a blood transfusion in the UK since 1 January 1980?
(Yes / No)

I have no objection to my body being transferred to another Medical School or Teaching Institute in Australia.
(Delete this if you object.)

I have no objection to the retention of some part/s of my body for museum preparations.
(Delete this if you object.)

I have no objection to my body being retained for more than four years but less than eight years.
(Delete this if you object.)

I declare that in the absence of any notice in writing signed by me to the effect that I have withdrawn my wishes or revoked my consents as set out above, any person empowered under the Anatomy Act 1977 and the Human Tissue Act 1983 to authorize the anatomical examination of my body or the removal of tissue from my body may treat each such wish and consent as not having been withdrawn or revoked.

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided in the Donor Information Statement, you have decided to participate.
Donor's Signature:

_____

I, the undersigned next-of-kin/ executor of the donor. Have no objection to the consents he/she has given.

Signature of next-of-kin/ executor: _____

Name: _____

Address: _____

Relationship to donor (if any): _____

Date: _____

Witness' signature: _____

Name: _____

Address: _____

Date: _____

Return one original to: Bequeathal Program, School of Medical Sciences,

University: _____

Please retain one copy of this form for your records.