The Albany Medical College deeply appreciates your desire to bequeath your body for the purpose of medical education and/or research. In order for this matter to be handled in an orderly fashion, the following suggestions are offered:

Read these documents carefully and complete the forms. Return the appropriate copy of the DOC, along with the Statistical Information Sheet to:

**Albany Medical College**
**Anatomical Gift Program MC – 135**
**47 New Scotland Ave.**
**Albany, NY 12208**

The second copy should be kept by the person who will be contacting Albany Medical College at the time of the donor’s death, perhaps a next-of-kin, physician, attorney, clergyman, etc. The third copy should be kept by the donor for his/her records. We strongly suggest that donors discuss their wishes with family and friends so that everyone is aware of the Anatomical Gift Program’s policies and procedures.

In the event of your death, a member of your family or other appropriate individual should notify the Anatomical Gift Program at (518) 262-5379 to determine whether your donation can be accepted and, if so, for instructions as to how to proceed. The College will need pertinent information about the donor, such as name, cause of death and age. We will also need the name, address and telephone number of the next-of-kin or person designated as power of attorney.

Upon notification and acceptance of your donation**, Albany Medical College will arrange for removal and transportation of the body to the College. Should death occur at a distance, which makes timely delivery to the Albany Medical College impractical or excessively expensive, or should you move from the Capital District, we would be happy to provide the name and address of the nearest medical school with an anatomical gift program.

**Please note, however, that from approximately December 18th through January 3rd of each year, the Program must be closed due to the temporary unavailability of certain resources necessary to its acceptance of donors’ gifts. The Program will therefore be unable to accept any donor’s remains during those times, and his or her family will need to make other arrangements for their disposition.

Shortly after receipt of your completed Declaration of Consent, you will receive a letter of acknowledgment and enrollment in the Anatomical Gift Program. (Please note, however, that enrollment does not constitute acceptance of your gift by the College, since that decision must be based on available Program capacity and other factors in existence at that time.) If you have any questions, please feel free to write or call the Anatomical Gift Program at the address and/or telephone number listed above.

Again, thank you for your very generous spirit in this matter and please be assured that you are making a noteworthy contribution to the education of young physicians.

Michael P. Smith, Ph. D.
Director

Julie Carpenter
Program Coordinator
ALBANY MEDICAL COLLEGE ANATOMICAL GIFT PROGRAM
DECLARATION OF CONSENT

As authorized by the provisions of the Uniform Anatomical Gift Act of the Public Health Law of the State of New York, I direct that, immediately after my death, Albany Medical College, be so notified and that within 24 hours following my death, my body be made available to them for the purpose of medical education and/or research.

Anatomical Gift Program, (518) 262-5379, fax (518) 262-5136

- It is understood that receipt of this Declaration of Consent does not constitute a guarantee that Albany Medical College will ultimately accept the donation of my remains, since that decision must be made in light of all circumstances in existence at the time of my death.

- Upon its acceptance of the donation**, the College will arrange with a contracted funeral home to have my remains transferred to Albany Medical College, within 24 hours of death, and within a 100 mile radius of the Albany Medical College, at College expense (death certificates, obituaries, register books, prayer cards, a memorial service other than AMCs, etc., are not included). If death shall occur outside the 100 mile radius, we will, upon such acceptance, make arrangements for the transportation of my body to the Medical College. In this case, however, the College will reimburse a Funeral Director for the transportation expenses only, not to exceed the amount of $300.00; and any additional expenses will be borne by my estate and I have so directed my family and/or the executor or administrator of my estate. If preferred, a specific funeral home may be used however they must agree to the Albany Medical College’s payment structure and all additional costs are borne by my estate.

  **Please note, however, that from approximately December 18th through January 3rd of each year, the Program must be closed due to the temporary unavailability of certain resources necessary to its acceptance of donors’ gifts. The Program will therefore be unable to accept any donor’s remains during those times, and his or her family will need to make other arrangements for their disposition.

It is understood that a determination of the acceptability of my remains will be made at the time of death and that the Albany Medical College reserves the right to decline the donation under conditions where there is family dissent, where my remains are deemed unsuitable for educational or research purposes, or for other reasons such as current lack of sufficient physical capacity to accept additional donations. Examples of unsuitability of remains include extreme decomposition, autopsy, infectious disease or weight limitations. In the event Albany Medical College declines my donation, alternate arrangements for the disposition of my body must be made by my family or otherwise on behalf of my estate.

- Albany Medical College encourages organ donation, and will not decline your donation by reason of organ donation.

- It is understood that following acceptance of my donation the Albany Medical College may, if desired, perform tests for infectious diseases or request copies of my recent medical records for such purposes as to determine the suitability of applicable studies. The Anatomical Gift Program does not release findings or medical records.

- It is understood that at times of need, my remains may be transferred to another medical school or allied health school for the purposes of medical education and/or research, unless I have notified the Albany Medical College otherwise, in writing.

I have a read and understand the statements contained within this Declaration of Consent

Signature ____________________________
Following their use for educational and/or research purposes (approximately 12 to 24 months), all bodies are individually cremated. One of the following interment options for the final disposition of the cremains **MUST** be checked:

<table>
<thead>
<tr>
<th>I would like my cremains interred in one of the Albany Medical College plots:</th>
<th>I would like my cremains returned to my family or heirs. Please notify the following individual when the ashes are available for return:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Albany Rural Cemetery [ ] St. Agnes Catholic Cemetery</td>
<td>Relationship to you? __________________________</td>
</tr>
<tr>
<td>Please notify the following individual of the memorial and interment service:</td>
<td>Name __________________________</td>
</tr>
<tr>
<td>Relationship to you? __________________________</td>
<td>Address __________________________</td>
</tr>
<tr>
<td>Name __________________________</td>
<td>Telephone __________________________</td>
</tr>
<tr>
<td>Address __________________________</td>
<td>E-Mail Address __________________________</td>
</tr>
<tr>
<td>Telephone __________________________</td>
<td>(if available)</td>
</tr>
</tbody>
</table>

Alternate individual in event the above cannot be contacted:

| Relationship to you? __________________________ |
| Name __________________________ |
| Address __________________________ |
| Telephone __________________________ |
| E-Mail Address __________________________ |
| (if available) |

According to the law of the State of New York, donors of bodies must be of sound mind and be at least eighteen years of age. This document must be signed by the donor in the presence of two witnesses who are at least 18 years of age. These forms need not be notarized.

**Please print or type all information clearly:**

Name (Mr.-Mrs.-Miss-Ms.) __________________________

Address __________________________

Telephone(____) __________________________

Date of Birth __________________________

Social Security # __________________________

Donor’s Signature __________________________

Date __________________________

Witness Signature __________________________

Date __________________________

Witness Signature __________________________

Date __________________________
Statistical Information Sheet Concerning Donor (Yourself) is Required for the Proper Completion of the Death Certificate. (Please print or type)

Name: First_________________ M.____ Last_________________ DOB:_________________

City & State of Birth________________________________________ SS# __________________

Current Address & County____________________________________

Phone #_________________ Race_________________ Height __________ Weight__________

US Armed Force? No _____ Yes _____ War or Service Dates________________________

Usual Occupation (do not enter retired) ___________________________ City/St.________________________

Kind of Business or Industry____________________________________ Homemaker Y____ N____

Education Level <8th gr.______ 9th-12th gr. W/ Diploma _______ 9th-12th W/GED _______

College: Associate’s Degree ______ Bachelor’s Degree ______ Doctorate/Professional Degree _______

Fathers Full Name __________________________ Fathers Place of Birth City & St.________________________

Mothers First& Maiden Name __________________________ Place of Birth City & St.________________________

Marital Status: ___________ Spouse’s First & Maiden Name __________________________

Spouse’s Address & Phone # (if different) __________________________

Physician: Name __________________________

Address __________________________

Telephone________________________

Medical History and other Pertinent Information is vital to determine the suitability of applicable studies. This Information will NOT hinder your donation

Check any of the following which you may have incurred:

☐ Pacemaker ☐ Coronary bypass surgery ☐ Coronary valve replacement

☐ Knee Replacement ☐ Hip Replacement ☐ Abdominal Surgery ☐ Hysterectomy

Please list chronic conditions and any major procedures or surgeries not listed above:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
ALBANY MEDICAL COLLEGE ANATOMICAL GIFT PROGRAM
DECLARATION OF CONSENT

As authorized by the provisions of the Uniform Anatomical Gift Act of the Public Health Law of the State of New York, I direct that, immediately after my death, Albany Medical College, be so notified and that within 24 hours following my death, my body be made available to them for the purpose of medical education and/or research.

Anatomical Gift Program, (518) 262-5379, fax (518) 262-5136

- It is understood that receipt of this Declaration of Consent does not constitute a guarantee that Albany Medical College will ultimately accept the donation of my remains, since that decision must be made in light of all circumstances in existence at the time of my death.

- Upon its acceptance of the donation**, the College will arrange with a contracted funeral home to have my remains transferred to Albany Medical College, within 24 hours of death, and within a 100 mile radius of the Albany Medical College, at College expense (death certificates, obituaries, register books, prayer cards, a memorial service other than AMCs, etc., are not included). If death shall occur outside the 100 mile radius, we will, upon such acceptance, make arrangements for the transportation of my body to the Medical College. In this case, however, the College will reimburse a Funeral Director for the transportation expenses only, not to exceed the amount of $300.00; and any additional expenses will be borne by my estate and I have so directed my family and/or the executor or administrator of my estate. If preferred, a specific funeral home may be used however they must agree to the Albany Medical College’s payment structure and all additional costs are borne by my estate.

**Please note, however, that from approximately December 18th through January 3rd of each year, the Program must be closed due to the temporary unavailability of certain resources necessary to its acceptance of donors' gifts. The Program will therefore be unable to accept any donor's remains during those times, and his or her family will need to make other arrangements for their disposition.

It is understood that a determination of the acceptability of my remains will be made at the time of death and that the Albany Medical College reserves the right to decline the donation under conditions where there is family dissent, where my remains are deemed unsuitable for educational or research purposes, or for other reasons such as current lack of sufficient physical capacity to accept additional donations. Examples of unsuitability of remains include extreme decomposition, autopsy, infectious disease or weight limitations. In the event Albany Medical College declines my donation, alternate arrangements for the disposition of my body must be made by my family or otherwise on behalf of my estate.

- Albany Medical College encourages organ donation, and will not decline your donation by reason of organ donation.

- It is understood that following acceptance of my donation the Albany Medical College may, if desired, perform tests for infectious diseases or request copies of my recent medical records for such purposes as to determine the suitability of applicable studies. The Anatomical Gift Program does not release findings or medical records.

- It is understood that at times of need, my remains may be transferred to another medical school or allied health school for the purposes of medical education and/or research, unless I have notified the Albany Medical College otherwise, in writing.

I have a read and understand the statements contained within this Declaration of Consent

Signature ______________________
Following their use for educational and/or research purposes (approximately 12 to 24 months), all bodies are individually cremated. One of the following interment options for the final disposition of the cremains **MUST** be checked:

<table>
<thead>
<tr>
<th>I would like my cremains interred in one of the Albany Medical College plots:</th>
<th>I would like my cremains returned to my family or heirs. Please notify the following individual when the ashes are available for return:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Albany Rural Cemetery [ ] St. Agnes Catholic Cemetery</td>
<td>Relationship to you? ___________________________</td>
</tr>
<tr>
<td>Please notify the following individual of the memorial and interment service:</td>
<td>Name______________________________</td>
</tr>
<tr>
<td>Relationship to you? ___________________________</td>
<td>Address______________________________</td>
</tr>
<tr>
<td>Name______________________________</td>
<td>Telephone______________________________</td>
</tr>
<tr>
<td>Address______________________________</td>
<td>E-Mail Address _________________________</td>
</tr>
<tr>
<td>Telephone______________________________</td>
<td>(if available)</td>
</tr>
</tbody>
</table>

Alternate individual in event the above cannot be contacted:

| Relationship to you? ___________________________ | Name______________________________ |
| Name______________________________ | Address______________________________ |
| Telephone______________________________ | E-Mail Address _________________________ |
| (if available) |

According to the law of the State of New York, donors of bodies must be of sound mind and be at least eighteen years of age. This document must be signed by the donor in the presence of two witnesses who are at least 18 years of age. These forms need not be notarized.

**Please print or type all information clearly:**

Name (Mr.-Mrs.-Miss-Ms.) ____________________________________________

Address ____________________________________________________________ street  city  state  zip code  

Telephone(____) _______________________ Date of Birth ___________ Social Security ________________

Donor's Signature ___________________________________________ Date ___________

Witness Signature ___________________________________________ Date ___________

Witness Signature ___________________________________________ Date ___________
ALBANY MEDICAL COLLEGE ANATOMICAL GIFT PROGRAM
DECLARATION OF CONSENT

As authorized by the provisions of the Uniform Anatomical Gift Act of the Public Health Law of the State of New York, I direct that, immediately after my death, Albany Medical College, be so notified and that within 24 hours following my death, my body be made available to them for the purpose of medical education and/or research.

Anatomical Gift Program, (518) 262-5379, fax (518) 262-5136

- It is understood that receipt of this Declaration of Consent does not constitute a guarantee that Albany Medical College will ultimately accept the donation of my remains, since that decision must be made in light of all circumstances in existence at the time of my death.

- Upon its acceptance of the donation**, the College will arrange with a contracted funeral home to have my remains transferred to Albany Medical College, within 24 hours of death, and within a 100 mile radius of the Albany Medical College, at College expense (death certificates, obituaries, register books, prayer cards, a memorial service other than AMCs, etc., are not included). If death shall occur outside the 100 mile radius, we will, upon such acceptance, make arrangements for the transportation of my body to the Medical College. In this case, however, the College will reimburse a Funeral Director for the transportation expenses only, not to exceed the amount of $300.00; and any additional expenses will be borne by my estate and I have so directed my family and/or the executor or administrator of my estate. If preferred, a specific funeral home may be used however they must agree to the Albany Medical College’s payment structure and all additional costs are borne by my estate.

**Please note, however, that from approximately December 18th through January 3rd of each year, the Program must be closed due to the temporary unavailability of certain resources necessary to its acceptance of donors' gifts. The Program will therefore be unable to accept any donor's remains during those times, and his or her family will need to make other arrangements for their disposition.

It is understood that a determination of the acceptability of my remains will be made at the time of death and that the Albany Medical College reserves the right to decline the donation under conditions where there is family dissent, where my remains are deemed unsuitable for educational or research purposes, or for other reasons such as current lack of sufficient physical capacity to accept additional donations. Examples of unsuitability of remains include extreme decomposition, autopsy, infectious disease or weight limitations. In the event Albany Medical College declines my donation, alternate arrangements for the disposition of my body must be made by my family or otherwise on behalf of my estate.

- Albany Medical College encourages organ donation, and will not decline your donation by reason of organ donation.

- It is understood that following acceptance of my donation the Albany Medical College may, if desired, perform tests for infectious diseases or request copies of my recent medical records for such purposes as to determine the suitability of applicable studies. The Anatomical Gift Program does not release findings or medical records.

- It is understood that at times of need, my remains may be transferred to another medical school or allied health school for the purposes of medical education and/or research, unless I have notified the Albany Medical College otherwise, in writing.

I have a read and understand the statements contained within this Declaration of Consent

Signature ________________________________
Following their use for educational and/or research purposes (approximately 12 to 24 months), all bodies are individually cremated. One of the following interment options for the final disposition of the cremains **MUST** be checked:

<table>
<thead>
<tr>
<th>I would like my cremains interred in one of the Albany Medical College plots:</th>
<th>I would like my cremains returned to my family or heirs. Please notify the following individual when the ashes are available for return:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Albany Rural Cemetery ☐ St. Agnes Catholic Cemetery</td>
<td>Relationship to you? ____________________________</td>
</tr>
<tr>
<td>Please notify the following individual of the memorial and interment service:</td>
<td>Name: ____________________________</td>
</tr>
<tr>
<td>Relationship to you? ____________________________</td>
<td>Address: ____________________________</td>
</tr>
<tr>
<td>Name: ____________________________</td>
<td>Telephone: ____________________________</td>
</tr>
<tr>
<td>Address: ____________________________</td>
<td>E-Mail Address: ____________________________</td>
</tr>
<tr>
<td>Telephone: ____________________________</td>
<td>(if available)</td>
</tr>
</tbody>
</table>

Alternate individual in event the above cannot be contacted:

| Relationship to you? ____________________________ | Name: ____________________________ |
| Name: ____________________________ | Address: ____________________________ |
| Address: ____________________________ | Telephone: ____________________________ |
| Telephone: ____________________________ | E-Mail Address: ____________________________ |

(if available)

According to the law of the State of New York, donors of bodies must be of sound mind and be at least eighteen years of age. This document must be signed by the donor in the presence of two witnesses who are at least 18 years of age. These forms need not be notarized.

**Please print or type all information clearly:**

Name (Mr.-Mrs.-Miss-Ms.) ____________________________

Address ____________________________ street __________ city __________ state __________ zip code

Telephone(____) ____________________________ Date of Birth __________ Social Security __________

Donor's Signature ____________________________ Date ____________________________

Witness Signature ____________________________ Date ____________________________

Witness Signature ____________________________ Date ____________________________