



# ALBANY MEDICAL COLLEGE

## ALBANY MED Health System

47 New Scotland Avenue, Mail Code 135, Albany, NY 12208

Phone: 518-262-5379

### ALBANY MEDICAL COLLEGE, ANATOMICAL GIFT PROGRAM DECLARATION OF CONSENT

As authorized by the provisions of the Uniform Anatomical Gift Act of Public Health Law (section 4301) of the State of New York, **I (print name)** \_\_\_\_\_, being of sound mind, and 18 years of age or older, direct that immediately after my death, Albany Medical College be notified, and that my body be made available to them for the purposes of medical education, research, and / or unrestricted gift purposes.

**It is understood that receipt of the Declaration of Consent does not constitute a guarantee that Albany Medical College will ultimately accept the donation of my remains - the decision to accept or decline a donation is made at the time of death.**

If donation is accepted, there will be no opportunity for next of kin to view the body once in the custody of Albany Medical College. My body shall be used for professional health education and research as determined by Albany Medical College, who may chemically preserve my body, or use my body in an un-embalmed state as an anatomical specimen. I further authorize the use of my body for purposes such as dissection, training procedures, study, physical exam, preservation techniques; and on occasion, a portion of the donated body may be retained, archived or photographed/filmed for extended teaching or research purposes without return to the whole for cremation.

**There will not be any release of information concerning reports, findings, use of body, or other test results.** On the occasion a study has been done, reports and findings are used for the study purposes only, and not released to individual's families.

Albany Medical College reserves the right to decline the donation under any condition where there is family dissent, or where the remains are deemed unsuitable for educational or research purposes. Such conditions may include - but are not limited to - extreme decomposition, serious trauma, infectious disease, exceeding height / weight ratio restrictions, or delayed notification of death. If Albany Medical College declines my donation, I understand that alternative arrangements must be made by my family or estate for the disposition of my body.

**We may also decline the donation if we simply lack sufficient physical capacity to accept additional donations.**

Please be advised that from approximately **December 18th through January 3rd** each year the program closes due to the maintenance of certain resources necessary to its' acceptance of donations. The program will not accept any donations during this time, and next of kin will need to make alternate arrangements for the disposition of the body.

Albany Medical College promotes the advancement of health education and postgraduate medical educations programs throughout New York State, and while most of our donors remain in Albany Medical Center, some may be transferred to other teaching facilities whose programs do not receive enough anatomical donors to meet their needs. These programs maintain compliance with all federal, state, and local laws and regulations governing anatomical donations. Each individual donor is tracked throughout the process, and returned to Albany Medical College for individual cremation. Without exception, at no time will the body be released to next of kin prior to cremation

**Following cremation, notification is sent to next of kin listed on this document. If no response is received within six months of that notification, the cremated remains will be interred in college plots at Albany Rural Cemetery.**

**Albany Medical College must be immediately notified of the death in order to consider acceptance. Do not rely solely upon medical personnel to make this notification, next of kin must proactively contact the program to ensure acceptance.**

Albany Medical College contracts with a local funeral home who is responsible for receiving the donor's body at this time. Upon notification, this funeral home will provide transportation of the donor at no cost to the estate (within a 100-mile radius only). If you choose to make your own arrangements with a funeral home, or if the death occurs outside of a 100-mile radius, or out of state, Albany Medical College will reimburse the funeral home for basic transportation and document expenses only, not to exceed the amount of \$300.00. There will be additional expenses due, and these will be borne by the decedent's estate or next of kin.

**I have read and understood the above information, and my next of kin is aware of my intent, and understands the above information:**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please complete all portions of this document

**(incomplete forms will not be accepted for processing)**, and mail to:

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

## Next of Kin and Disposition Information Page

Following their use for educational and/or research purposes, all bodies are individually cremated. One of the following options for the final disposition must be checked:

☐ I would like my cremated remains returned to family or heir listed below

☐ I would like my cremated remains to be interred in one of the Albany Medical College burial plots.

### PLEASE NOTE:

- **It should be anticipated that cremated remains may not be available for return for 24 months or longer**
- **We do not split or separate cremated remains for distribution to more than one family member**
- **We do not mail cremated remains outside of the United States**
- **Following notice of cremation to next of kin, if we do not receive a response back within six months, we will automatically inter cremated remains at the Albany Medical College burial plots.**

### Next of Kin Contact Information (Primary)

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Next of Kin Contact Information (Alternate)

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

		<b>Statistical Information</b> Information on this page is used for completion of the death certificate, as well as for placement in appropriate teaching programs. <b>All areas must be completed – incomplete forms will not be accepted for processing.</b>	
1. Name: (First, Middle, Last)			
2. Date of Birth:		3. Social Security #:	
4. Education:		5. Race:	
<div><input type="checkbox"/> 0 – 8 <input type="checkbox"/> 9 – 12, no diploma <input type="checkbox"/> High School (Grad/GED) <input type="checkbox"/> Associates <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate / Professional</div>		<div><input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian / Alaska Native <input type="checkbox"/> Other, Specify Below</div>	
		<div><b>US VETERAN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Specify years of service:</div>	
7. Mailing Address:			
8. Locality (Check one) <div><input type="checkbox"/> City of _____ <input type="checkbox"/> Town of _____ <input type="checkbox"/> Village of _____</div>			
9. County of Residence:		10. City/State of Birth: (if not US, provide town/country)	
11. Current Marital Status:		<div><input type="checkbox"/> Married   <input type="checkbox"/> Divorced   <input type="checkbox"/> Widowed   <input type="checkbox"/> Never Married</div>	
12. Spouse's Full Name: (Must include maiden name)			
13. Father's Full Name:			
14. Mother's Full Name: (Must include maiden name)			

<b>15. Occupation:</b>	
<i>Usual occupation, “retired” is not a permissible response</i>	
Type of business or industry: _____	
Company Name: _____	

<b>Height:</b>		<b>Weight:</b>	
If any of the below are applicable, please check:			
<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Coronary Bypass Surgery <input type="checkbox"/> Coronary Valve Replacement <input type="checkbox"/> Pacemaker <input type="checkbox"/> Hip Replacement			
<input type="checkbox"/> Knee Replacement <input type="checkbox"/> Amputee (specify below) <input type="checkbox"/> Abdominal Surgery (specify below)			
<input type="checkbox"/> Infectious Disease (specify below)			
In the space below, please provide clarification of any checked items, list any chronic conditions, major surgeries or procedures not listed above – and please include any additional information you would like to share with those you will be teaching!			

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

**NOTE: NEXT OF KIN OR OTHER RESPONSIBLE PARTIES MAY NOT SIGN ON BEHALF OF THE DONOR**

**Please print or type all information clearly, incomplete forms will not be processed.**

<b>DONOR NAME:</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Date of Birth:</b>	<b>Social Security Number:</b>	<b>Phone:</b>
<b>DONOR SIGNATURE:</b>		<b>Date:</b>
<b>WITNESS SIGNATURE:</b>		<b>Date:</b>
<b>WITNESS SIGNATURE:</b>		<b>Date:</b>