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 PROGAM
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. **At times throughout the year, our program may reach capacity limitations and decline the donation as a result**.

Albany Medical College promotes the advancement of health education and postgraduate medical education 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.

If donation is accepted, 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, provided the death occurs **within a 100-mile radius, and within the State of New York**.

Please note: We no longer accept donations from outside the State of New York.

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: _____

	Statistical Information Information on this page is used for completion of the death certificate, as well as for placement in appropriate teaching programs. All areas must be completed – incomplete forms will not be accepted for processing.

1. Name: (*First, Middle, Last)*

2. Date of Birth:		**3. Social Security #:**		
4. Education:	**[ ]** 0 – 8 **[ ]** 9 – 12, no diploma **[ ]** High School (Grad/GED) **[ ]** Associates **[ ]** Bachelor's **[ ]** Master's **[ ]** Doctorate / Professional	**5. Race:**	[ ] White [ ]Black/African American [ ] Asian [ ] Amer.Indian / Alaska Native [ ] Other, Specify Below **Of Hispanic Origin?** [ ] No [] Yes – please specify	**US VETERAN:** **[ ]** Yes **[ ]** No Specify years of service:

7. Mailing Address:

8. Locality *(Check one)* **[]** City of _____
[] Town of _____
[] Village of _____

9. County of Residence:		**10.City/State of Birth:** *(if not US, provide town/country)*	

11.Current Marital Status:	**[] Married [] Divorced [] Widowed []Never Married**
12. Spouse's Full Name: *(Must include **maiden** name)*	
13. Father's Full Name:	
14. Mother's Full Name: *(Must include **maiden** name)*	

15. Occupation: *Usual occupation,* ***"retired" is not a permissible response***	
	Type of business or industry: _____ **Company Name:** _____

Height:		**Weight:**	

If any of the below are applicable, please check:

[ ] Hysterectomy [ ] Coronary Bypass Surgery [ ] Coronary Valve Replacement [ ] Pacemaker [ ] Hip Replacement

[ ] Knee Replacement [ ] Amputee (specify below) [ ] Abdominal Surgery (specify below)

[ ] 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

By signing below, I affirm that:

- I am the individual identified in this document, and I am completing it on my own behalf.
- I understand that this form must be signed by me personally, and that no one - including family members, caregivers, or representatives - may sign it on my behalf.
- I understand that submitting this form on behalf of another person, or signing in someone else's name, may be considered fraudulent, and could result in the rejection of the donation.
- I acknowledge that Albany Medical College may request confirmation of identity or intent at the time of death, and that any inconsistency may render this form invalid.

DONOR NAME:		
Address:		
City:	**State:**	**Zip Code:**
Date of Birth:	**Social Security Number:**	**Phone:**

DONOR SIGNATURE:		**Date:**
WITNESS SIGNATURE:		**Date:**
WITNESS SIGNATURE:		**Date:**

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