



## BODY DONATION FORM

Date: \_\_\_\_\_  
(mm/dd/yyyy)

I hereby state that upon my death, I (Mr./Mrs./Ms./Mx.) \_\_\_\_\_  
(circle one) (print name)

wish my body to be turned over to the New York University Grossman School of Medicine to be preserved and used for purposes of medical education and research. Should an autopsy be needed, should my body be embalmed, should my organs be donated (eye donations **are** permissible), should I die of an infectious disease, or should any other condition render my body unsuitable for educational purposes, my family would assume the expense of disposition of my remains.

After use, your remains will be cremated and disposed of according to your wishes as outlined below (please select one),

- My remains will be **cremated** and **returned to my family**
- My remains will be **cremated** and **scattered in the Garden of Remembrance, Rosehill Cemetery, Linden, NJ.**

Do you give permission for the Office of Medical Education to retain body parts for educational or research purposes (please select one)?  Yes  No

### Donor Information

**Date of Birth** (mm/dd/yyyy) \_\_\_\_\_

**Sex**  Male  Female  Other

**Veteran**  Yes  No  Prefer not to say

**Marital Status**

Married

Single / Divorced / Widow(er)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Email

\_\_\_\_\_  
Telephone Number

### Witness (1)

### Witness (2)

\_\_\_\_\_  
Signature (1)

\_\_\_\_\_  
Signature (2)

\_\_\_\_\_  
Printed Name (1)

\_\_\_\_\_  
Printed Name (2)

**Next of Kin Information  
(Primary)**

Relationship to Donor

Name (printed)

Address

City, State Zip Code

Telephone Number

Email Address

**Next of Kin Information  
(Secondary/Optional)**

Relationship to Donor

Name (printed)

Address

City, State Zip Code

Telephone Number

Email Address

If you are married, and you choose to have your remains returned to someone **other** than your spouse, **please check the box below, have your spouse sign and date on the space provided, and have this form notarized.**

- I am the spouse of \_\_\_\_\_, and consent that their remains will **NOT** be returned to me but to the primary next of kin listed on this form.

Signature of Spouse

Date

State of \_\_\_\_\_  
County of \_\_\_\_\_

Signed and sworn (or affirmed) before me on \_\_\_\_\_ by \_\_\_\_\_.  
Date Printed name of individual making statement

Signature of Notary Public

Printed name of Notary Public

My Commission Expires: \_\_\_\_\_

**PLEASE SUBMIT COMPLETED FORMS BY MAIL, EMAIL, OR FAX**

**Mailing Address**

NYU Grossman School of Medicine  
Body Donation Program  
Office of Medical Education  
550 First Avenue, MS G52  
New York, NY 10016-6497

**Email:** Body.Donation@nyumc.org

**Telephone:** (212) 263-5378

**Fax:** (646) 501-0017