The University of Tennessee
Health Science Center
College of Medicine

Department of Anatomy and Neurobiology

Anatomic Gift by Living Donor

I,_____ do hereby dispose of and give my body, after death to The Department of
(Type or print DONOR'S FULL NAME)
Anatomy and Neurobiology, The University of Tennessee Health Science Center, or to its designee, for education or research for the advancement of medical, dental, or other health science or therapy. I request, authorize and instruct my surviving spouse, next-of-kin, executor, or the physician who certifies my death, to notify The Department of Anatomy and Neurobiology, The University of Tennessee Health Science Center IMMEDIATELY** after my death of the availability of my body.

SIGNED and WITNESSED this _____ day of _____, 2_____ at _____
(day of month) (Month) (year) (City and State)

Donor:
Date of Birth _____

Donor:
SIGN HERE:_____
Date

Social Security Number _____

_____
(Type or print name)

_____
(Street Address)

_____
(City) (State) (Zip)

On this _____ day of _____, 2_____, the person named above, _____ signed this document in our presence, and we, as attesting witnesses, at the request of the above name Testator or Testatrix, in his or her presence, and in the presence of each other, have also signed this document.

Witness: _____
(Signature) (Date)

_____
(Type or Print WITNESS' name)

_____
(Street Address)

_____
(City) (State) (Zip)

Witness: _____
(Signature) (Date)

_____
(Type or Print WITNESS' name)

_____
(Street Address)

_____
(City) (State) (Zip)

Instructions:

1. Fill out, date and sign this form in the presence of two witnesses. Have the witnesses sign where indicated. It is NOT necessary to have this form notarized.
2. Mail the SIGNED ORIGINAL form to:
   Attn: Administrator, Anatomical Bequest Program (ABP)
   The University of Tennessee Health Science Center
   855 Monroe Avenue
   Memphis, Tennessee 38163
3. After The University receives the properly completed form, you will be sent an identification card noting that you have made this donation. We will also send you a COPY of this form which you should keep with your personal papers, or give to your next-of-kin, attorney or physician.

PLEASE NOTIFY THE UNIVERSITY OF TENNESSEE IF YOU CHANGE YOUR PERMANENT ADDRESS AFTER YOU RECEIVE YOUR IDENTIFICATION CARD.

Mailing address: Attn: Administrator, Anatomical Bequest Program (ABP), Department of Anatomy and Neurobiology, 855 Monroe Avenue, Memphis, Tennessee 38163

****During the regular business hours (8:00 AM – 5:00 PM Central Time, Monday through Friday) telephone (901) 448-5978; After Hours, weekends, holidays, page Bequest Program representative at (901) 448-2640.**

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VITAL STATISTICS INFORMATION

Filling in the blanks below will help The University of Tennessee Health Science Center make certain that all information is on hand to complete your bequest, and prepare essential legal documents after death. **This information will be kept confidential.**

Full NAME _____ Sex _____ Did you serve in the military? _____
(First, middle, last) (yes or no)

Social Security Number: _____ Date of Birth: _____ Birthplace _____
(Month, day, year) (City and State or Foreign country)

Marital Status: Married,
Never married, widowed,
Divorced (specify) _____ Surviving Spouse _____
(If wife, give MAIDEN LAST NAME)

Usual Occupation (Give kind of work done during most of working life
DO NOT USE 'RETIRED') _____ Kind of business/industry _____

If of Hispanic Origin, specify
Cuban, Mexican, Puerto Rico, etc. _____ Race – American Indian,
Black, White, etc (specify) _____

Education: Specify ONLY the highest grade completed: Elementary or Secondary (0 – 12)_____ or College (1 -4 or 5+)_____

Father's Name _____ Mother's Name _____
(First, middle, last) (First, middle, last)

Your permanent address:

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(County) (Telephone Number)

Your height _____

Your weight _____

Right or Left handed _____

List name(s) and current address(es) of your next-of-kin

_____
(Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Relationship) (Telephone)

_____
(Name)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Relationship) (Telephone)

Please give the name(s), address(es) and telephone number(s) of any physician(s) who can provide information about your medical history.

_____

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(This space reserved for office use)

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