



Donor Authorization for Anatomical Gift to the University of Michigan Anatomical Donations Program

1. Consent

Being eighteen years of age or over and of sound mind, I hereby offer my body after death as an unrestricted anatomical gift to the University of Michigan Anatomical Donations Program ("Program").

Please mail completed forms to:
Anatomical Donations Program
3767 Medical Science Building II
1137 Catherine St.
Ann Arbor, MI 48109-1621

- I understand that my accepted body may be used for the purposes of education or research, both within UM or outside UM by another institution, in the sound judgment and sole discretion of the Program.
- I understand that the acceptance and exact use of my body will be at the discretion of the Program. In some cases such use may involve exposures to destructive or damaging forces (e.g., impacts, crashes, ballistic injuries, blasts). Examples of how the gift might be used for education or research include: medical education and training; forensic sciences (e.g., pathology, engineering, anthropology); vehicle safety or the development of protective equipment (e.g., military, law enforcement, sports).
- I understand that, for the purposes of education or research, the Program reserves the right to create and share/distribute photographic, video, extended reality renderings, or other multimedia of my donation in ways that are de-identified and with respect for my dignity.
- I understand that the Program will not return any medical or cosmetic implants, prostheses, or devices.

2. Applicable Law and Policies

I understand this donation is subject to applicable law and Program policies in effect at the time of my death.

3. Duration of Donation

My preference regarding the duration of my donation is as follows (choose **only one** option):

_____ **Temporary Donation:** My donation will be used in any manner that the Program deems appropriate, within or external to the University of Michigan. Within approximately 24 months of my donation, the Program will cremate the donor's (my) body and the ashes will be made available for return. I understand that, for the purposes of education or research, the Program reserves the right to preserve and/or retain a portion of my donation indefinitely, including, but not limited to: tissues/histological (microscopic) samples, portions of bone/organs, and whole organs or organ systems. These retained portions will not be included in the ashes that are made available for return after approximately 24 months. Upon the completion of their use, the Program will cremate the retained portions and/or bury those remains at a University of Michigan burial plot. Remains of retained portions will not be returned. **OR,**

_____ **Permanent Donation:** The Program may retain my entire donation indefinitely to be used in any manner that the Program deems appropriate, within or external to the University of Michigan, without time constraints on the use of the donor's body. Following use of the donation, the Program will cremate the donor's (my) body and bury the remains at the University of Michigan burial plot. When Permanent Donation is selected, the remains will not be returned.

4. Release of Medical Information

I authorize any and all health care providers (e.g. hospitals, nursing homes, physician practices) holding my health information at the time of my death to release my health information to the Program and funeral facility personnel for the purpose of implementing my donation. Release of my health information may be in oral and/or written form, including copies of my medical records. This authorization extends to the release of information, if any, regarding: alcohol and drug/abuse treatment; psychosocial and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; and genetic information. The Program will follow all applicable law as well as University of Michigan policies to ensure the confidentiality of my health information, but I understand that once a health care provider or the Program discloses my health information to a recipient, neither the health care provider nor the Program can guarantee that the recipient will not re-disclose my health information. The Program is not liable for the actions of others who may further disclose the information.

5. Further Information

This authorization is voluntary and no treatment, payment, or enrollment or eligibility for benefits is conditioned upon my signing this form. This authorization expires only upon the revocation of my anatomical gift. For information on revoking this authorization and delivering a revocation, please contact the Program.

My signature below confirms that I have read the "Gift of Knowledge" informational guide attached to this Donor Authorization form. I understand any questions that may arise may be directed to the Program, by phone at (734) 764-4359 or by email at donorinfo@umich.edu.

Signatures

DONOR

Mr./Mrs./Ms./Dr./Other; (Circle one) Name (Please Print) _____

Date of Birth _____ Signature _____

Street Address _____

City, State, Zip Code _____

Telephone _____ Date of Signature _____

WITNESSES

The Donor signed this Authorization for Anatomical Donation, and we, in the Donor's presence and at the Donor's request, have provided our names as witnesses to the Donor's signature. We state that the Donor appears to be at least eighteen years of age and appears to be of sound mind and not under or subject to undue influence.

Witness 1

Name (Please Print) _____

Signature _____

Street Address _____

City, State, Zip Code _____

Telephone _____

Witness 2

Name (Please Print) _____

Signature _____

Street Address _____

City, State, Zip Code _____

Telephone _____

Please retain a copy of this form for your records.