MEDCURE

AUTHORIZATION OF BODY GIFT

For office use only

Validated by: _____

Date: _____

For assistance please contact us 24/7 at 866-560-2525. Incomplete or inaccurate forms will be returned for correction.
IF BEFORE DEATH, this form must be completed by the donor or his/her Power of Attorney for Healthcare.
IF AFTER DEATH, this form must be completed by the next of kin.

Donor's Full Legal Name: _____

(Legal name on file with the Social Security Office; if applicable, include Jr., Sr., II, III, etc.)

Is the prospective donor currently receiving hospice care or have a life-expectancy of six months or less? ☐ **YES** ☐ **NO**

Donor's Date of Birth: Month _____ Day _____ Year _____

My Relationship to the Donor is: _____ Priority order = 1. Self 2. Power of Attorney for Healthcare
(if Power of Attorney send full and complete document) 3. Spouse 4. Adult child 5. Parent 6. Sibling 7. Next degree of kindred 8. Donor's Estate Representative

I authorize that this whole body donation gift is motivated exclusively by altruistic intentions without monetary compensation or valuable consideration made to me or any family member. I understand an autopsy will NOT be performed to determine the cause or contributing factors that led to the death of the donor. I also authorize the procurement of all necessary tissues, organs, and anatomical specimens, including whole body, for medical research and educational purposes and understand tissue/specimens may be used indefinitely into the future. I understand that the body may be subject to extensive preparation and/or long-term preservation, including but not limited to, removal of the head, arms, legs, hands, feet, spine, organs, tissues, or fluids. No promise or assurance has been given that this donation will benefit a specific use, research, or educational study. This gift may benefit multiple educational, scientific, organ procurement and medical research organizations, for profit or nonprofit, domestic or international, and the education or research institution may perform final specimen disposition.

I authorize any and all medical information to be released to MEDCURE before or after death, including but not limited to, a complete medical history and blood samples. Blood testing will occur which may include, but is not limited to, HIV, hepatitis B and hepatitis C. Positive blood test results for HIV will be communicated to the Health Department; a positive test for HIV, hepatitis B or hepatitis C will be communicated to the next of kin. **Determination of acceptance of donation will be made at the time of passing**. Upon acceptance of donation, MEDCURE will be responsible for any costs related to the donation including transportation, cremation, return of partial cremated remains to family or a scattering of cremated remains at sea. MEDCURE reserves the right, at their sole discretion, to decline acceptance of the donation and related charges if it appears unsafe or unsuitable for the purposes consented to herein. The donor will be transported to a MEDCURE facility. All protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) will remain confidential and be kept in a secure location.

The cremated remains returned will not include body tissues, organs, or anatomical specimens procured for medical education or research purposes. An open casket viewing is not possible with whole body donation and no un-cremated remains will be returned. I agree to hold MEDCURE and all associated agents, including specimen end-users, harmless from loss or damage, including incidental and consequential damage which results from the undersigned not having proper legal authority to consent. This donation will benefit medical education, research studies, and training.

I have had adequate time for consideration, and all my questions have been answered. ☐ **YES**

I further authorize this whole body donation for additional education and research uses, such as weapons testing and personal protective gear (for example military); search, rescue, and recovery operations; forensic pathology and crime scene investigation; educational display; plastination (permanent plastic fixation of body tissues); or automobile safety research. In some cases such research or education may involve destruction of the body or parts of the body.

☐ **YES** ☐ **NO**

In all cases MEDCURE MUST have two witness signatures of persons 18 or older. Witnesses cannot be the person consenting to donation. At least one witness must also be a "disinterested party" (not a spouse, child, sibling, parent, grandchild, grandparent, or legal guardian of the prospective donor).

I understand that signing this document does not guarantee acceptance of donation.

I hereby verify my understanding of all listed disclosures as indicated by my signature below:

Signature of Consenter: _____ Print Name: _____

Date: _____ Address of Consenter: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ Email: _____

Signature of Witness #1: _____

Print Name: _____

Date Signed: _____

Relationship to Donor: _____

Signature of Witness #2: _____

Print Name: _____

Date Signed: _____

Relationship to Donor: _____

Please Send Death Certificate to (Name): _____ Relationship to Donor: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

MEDCURE | 18111 NE Sandy Blvd. | Portland, OR 97230 | Toll Free 1-866-560-2525 | Fax 503-257-9101 | Email donate@medcure.org

MEDCURE

CREMATION AUTHORIZATION

For office use only

Validated by: _____

Date: _____

If BEFORE death, this form must be completed by the donor or their Power of Attorney for Healthcare (if Power of Attorney send document in with this form). If AFTER death, this form must be completed by the next of kin.

I hereby authorize and direct the crematory selected by MEDCURE, Inc. ("Crematory"), subject to its rules and regulations, to cremate the body of

Donor's Full Legal Name: _____ **Date of Birth:** _____

(Legal name on file with the Social Security Office; if applicable, include Jr., Sr., II, III, etc.)

My Relationship to the Donor is: _____ Priority order = 1. Self 2. Power of Attorney for Healthcare

(if Power of Attorney send full and complete document) 3. Spouse 4. Adult child 5. Parent 6. Sibling 7. Next degree of kindred 8. Donor's Estate Representative

Upon my oath and under penalty of perjury I hereby swear and affirm that to the best of my knowledge there is no other person having prior right to give this authorization to control the remains of the above-named decedent. I hereby agree to hold the Crematory, Funeral Director, MEDCURE, or person acting as such, their officers and employees harmless from any liability cost or expenses resulting from this authorization. I further understand that the cremation process is subject to the following terms and conditions.

The body presented to Crematory is that of the named deceased as identified in accordance with MEDCURE procedures.

For sanitation purposes it is the policy of the Crematory that the body be placed in a rigid enclosed container. All prostheses (hip joints, surgical pins, etc.), bridgework or similar items will be discarded after the cremation process is completed. Gold inlays and fillings, rings and jewelry will lose their identity and will also be discarded. Pulverizing the cremated remains by crushing and grinding is part of the normal process involved in preparing the cremated remains. The bulk of the pulverized cremated remains will be returned; however, some will be irreclaimable during processing and containerization. The amount of processed cremated remains may exceed the capacity of the urn or temporary container. Any excess cremated remains will be placed in a separate container and will accompany the primary urn or temporary container when released. Persons authorizing cremation shall, at his or her sole expense, agree to defend, hold harmless, and indemnify the Crematory its officers, directors, employees, and agents from any claim, liability, suit, cause of action, cost of expenses (including, without limitation, reasonable attorney's fees incurred) resulting, in any way, from reliance on or performance consistent with the direction, declarations, representation, authorizations, and agreements herein, including but not limited to any delay in or damage arising from the transportation of the decedent's body or cremated remains. If shipment of cremated remains is required, I direct they be shipped via Express Mail.

PACEMAKER ALERT: Does the donor have a pacemaker? ☐ **YES (I authorize its removal)** ☐ **NO**

INTERNAL RADIATION ALERT: Has the donor received any intravenous or surgically implanted radiation treatments such as Metastron (Strontium 89) or brachytherapy seeds?

☐ **YES (Approx. date of last treatment:** _____**)** ☐ **NO**

DISPOSITION OF CREMATED REMAINS (please mark only one option)

☐ Cremated remains are to be sent to (name of recipient)*: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

- OR -

☐ MEDCURE will arrange for a scattering at sea within 8 months of donation ☐ with notification ☐ without notification

* Please notify us if address of person to receive cremated remains changes. If cremated remains are returned due to undeliverable address, reasonable effort will be made in accordance with MEDCURE's policy and procedures to contact the intended recipient. If contact is unsuccessful, the cremated remains of the donor will be scattered at sea within one year of donation.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE.
All fields must be filled out. Two witness signatures required.

Signature of Consenter: _____ **Print Name:** _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone Number:** _____

Date Signed: _____ **Time Signed:** _____ ☐ AM ☐ PM

Signature of Witness #1: _____

Print Name: _____

Date Signed: _____

Relationship to Donor: _____

Signature of Witness #2: _____

Print Name: _____

Date Signed: _____

Relationship to Donor: _____

Portland Cremation Center, LLC
17819 NE Riverside Pkwy, Ste. A
Portland, OR 97230-7377

La Paloma Funeral Service
5450 Stephanie St., Ste. 110
Las Vegas, NV 89122

Orlando Crematory
7284 Narcoossee Rd.
Orlando, FL 32822

St. Louis Cremations
2135 Chouteau Ave.
St. Louis, MO 63103

MEDCURE

DEATH CERTIFICATE VITALS WORKSHEET

WARNING: It is critical that you provide accurate information that matches legal records. Any incorrect, misspelled, illegible, or unofficial answer will invalidate the Death Certificate MEDCURE provides. If any answer is impossible to obtain, write "UNKNOWN." If possible, please type your answers. If not, please write VERY clearly in all capital letters.

Donor's Full Legal Name: _____ Date of Birth: _____
(Legal name on file with the Social Security Office; if applicable, include Jr., Sr., II, III, etc.)

Maiden Name (if applicable): _____ Birthplace: _____
City & State, or County

Sex: ☐ Female ☐ Male Social Security Number (if preferred, may be provided verbally over the phone): _____

Residence State: _____ Since: _____ County: _____ Since: _____

Current Street Address: _____ City: _____

State: _____ Zip Code: _____ Lived at Current Address Since: _____ Inside City Limits? ☐ Yes ☐ No

Previous State of Residence: _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Spouse's Name (if applicable): _____ _____ _____ _____
First Middle Last (Maiden Name)

Race: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American Tribe: _____
☐ Pacific Islander ☐ Other: _____

Father's Name: _____ _____
First Last

Father's Birthplace: _____

Mother's Name: _____ _____ _____
First Last (Maiden Name)

Mother'sBirthplace: _____

Donor's Education Level: ☐ Grade School (Grade Level: ____) ☐ GED ☐ High School (Grade Level: ____) ☐ Some College
(check only 1 box indicating highest education level achieved)
☐ Trade/Vocational ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Professional/Doctorate ☐ Unknown

Usual Occupation: _____ Industry: _____

Years in Occupation: _____ Name / Location of Last Employer: _____

U.S. Military Service: ☐ Yes ☐ No Branch: _____ Discharge Date: _____ Serial Number: _____

Combat Served: ☐ Yes ☐ No War Served: _____

Person Completing Form: _____ Relationship to Donor: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Today's Date: _____

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