TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Institute *of* Anatomical Sciences
Willed Body Program

3601 4th Street STOP 6528
Lubbock, Texas 79430-6528
T 806.743.2708 | F 806.743.9455
WBP.Lubbock@ttuhsc.edu

SELF DONATION FORM
(Please Print or Type)

TO WHOM IT
MAY CONCERN: _____
FIRST MIDDLE LAST

being of sound mind and disposition, desire that after death my body be used for the advancement of medical science education, training and research. I do hereby will and bequeath my body to the Texas Funeral Service Commission (TFSC) as represented by the TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER INSTITUTE OF ANATOMICAL SCIENCES-WILLED BODY PROGRAM (TTUHSC-IAS-WBP).

TTUHSC-IAS-WBP 3601 4th St. STOP 6528 Lubbock, Texas 79430 (806)-743-2708.

I understand that the TTUHSC-IAS-WBP will transport and prepare my remains, if accepted, for medical science education, training and research. It is also understood that, even though TTUHSC-IAS-WBP serves approximately a 300-mile radius from our institution, donors who live outside Lubbock County may/will have to arrange with a local funeral home entity to pick up and hold their body at the time of passing, until the TTUHSC-IAS-WBP can arrange transportation to the institution. Any services provided by a funeral home will be the responsibility of my next of kin/executor of my estate. I hereby instruct my representative to make necessary transportation arrangements or authorize that my body be delivered to a closer institution approved by the Texas Funeral Service Commission (TFSC).

I understand that the Willed Body Program reserves the right to decline a body that is registered with the Willed Body Program and that no guarantee exists that my body will be accepted at the time of death. I understand that if I am morbidly obese, or have a contagious disease (e.g. HIV, Hepatitis, TB, M.R.S.A., etc.); have damage from trauma; have internal organs removed (for transplantation), have an autopsy; or if I commit suicide, my body donation may be declined by the Willed Body Program. If the Willed Body Program declines the donation, my next of kin/executor of my estate must make other arrangements for my body's final disposition. The Willed Body Program is not responsible for any costs associated with other necessary arrangements.

In order to ensure informed consent, the Willed Body Program only receives body donations from first-person donations or next-of-kin donations.

I understand that cremation is the final disposition of my remains and that my next of kin/executor of my estate can request the residual cremated remains be returned and only if the request is made in writing at the time of my death when the donation is initiated. I understand that the policy of the Willed Body Program is that the cremated remains of individuals that **are not requested for return in writing,** will be irretrievably co-mingled then buried in the TTUHSC-IAS- Willed Body Program ossuary.

I hereby relinquish all rights and claims regarding my body including all medically implanted items and/or substances. I h e r b y direct that by accepting and using this body for teaching and scientific purposes and its subsequent disposition, neither the TFSC, nor any receiving institution, shall incur any liability, and no manner of claim shall arise against the TFSC or a receiving institution. I authorize the TFSC to transport the willed/donated body described out of the State of Texas in the event that the holding institution and TFSC have determined that an excess of bodies currently exists in the State of Texas.

Complaints or inquiries regarding a willed or donated body should be directed to the TFSC: via phone 512-936-2474 or email:anatomical@tfsc.texas.gov

SIGNATURE
OF DONOR: _____ PRINT: _____ DATE: _____

Date of Birth: _____ SEX M ☐ F ☐ Social Security Number: _____

Address: _____ City _____ State _____ Zip _____

2 WITNESSES REQUIRED: Anyone OVER THE AGE OF 18 (including relatives) *Notary not necessary*

WITNESS #1: _____ PRINT: _____

Address: _____ City _____ State _____ Zip _____

WITNESS#2: _____ PRINT: _____

Address: _____ City _____ State _____ Zip _____

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PERSONAL DATA FORM
(Please Print or Type)

Social Security #:_____ Date:_____

Full Name: _____
first middle last maiden name (if applicable)

Address:_____ yes ☐ no ☐
street city county state zip inside city limits?

Email:_____ Telephone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Place of Birth: _____
month day year city county state

Individuals Education (Check the box that best describes the highest degree or level of school completed)

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

Individual of Hispanic Origin? (Check the box that best describes you, Spanish/Hispanic/Latino. Check the "no" box if you are not Spanish/Hispanic/Latino)

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino
- ☐ (Specify) _____

Individual's Race (Check one or more races to indicate what you consider yourself to be)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ (Name of the enrolled or principal tribe)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify)_____
- ☐ Other (Specify)_____

Ever in the Armed Forces? ☐ yes ☐ no	Ever a Peace Officer in this State? ☐ yes ☐ no
Usual Occupation (Indicate type of work done during most of working life. DO NOT USE RETIRED)	Type of Business/Industry

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

Spouse: _____
first middle last (included maiden name if applicable)

Please list parent's names, even if deceased.

Father's Name: _____
first middle last

Mother's Name: _____
first middle maiden name

For Notification:
Immediate Next of Kin:_____ Relationship:_____

Address:_____ yes ☐ no ☐
street city county state . zip inside city limits?

Email:_____ Telephone: _____

Veterans -- Please complete the following

Branch of Service:_____ Military Rank:_____ Military Unit: _____

Military Serial Number:_____ Entry Date:_____ Discharge Date:_____ Type of Discharge: _____

Please keep this information current with our office
Please complete & return with white copy of Donation Form

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(COMPLETE AND RETURN)

Willed Body Program Cremation Form

The procedure for disposition of bodies upon completion of Anatomical Studies is cremation.

If this form is not returned, the next of kin or executor relinquish their rights to the cremated remains.

Please *Initial* next to your decision (place n/a in other space) and sign/complete the information below

_____ **I DO NOT** wish cremated remains to be returned. Texas Tech University Health Science Center Willed Body Program will arrange for the proper disposition of the cremated remains by irretrievably co-mingling them in their ossuary.

OR

_____ **I WISH** the cremated remains to be returned. Contact will be made via phone, email, or letter, at the time of cremation to arrange for the return of the cremated remains, this could take up to 24 months from the date of death. The cremated remains could be returned by in person appointment or U.S. Postal Service (via Priority Mail Express, return receipt requested).

Signature Date

Print Name Relationship

Address

City, State, Zip Code Phone Email

Complete if delivery is to another individual:

Name Address

City, State, Zip Code Phone: Email:

Enter Donor Name ONLY below this line

Name of Deceased SAB Number

Date of Death Date of Receipt

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Medical Assessment Questionnaire

Note: The person completing this form should answer ALL questions YES or NO, to the best of your knowledge; comment and elaborate on all questions marked YES. (Additional space for expanded comments available on page 3)

Donor Initials: _____ Age:_____ Sex: ◯ Male ◯ Female _____ height _____ weight

Has s/he been hospitalized in the past two years? Reason: _____ ☐ Yes ☐ No

Did s/he Have any serious illnesses or infections in the past? ☐ Yes ☐ No
What type and when? _____

Have any surgical procedures in the past? ☐ Yes ☐ No
What type and when? _____

Has s/he ever been diagnosed with the following contagious illnesses?
A. HIV or AIDS ☐ Yes ☐ No
B. Hepatitis B ☐ Yes ☐ No
C. Hepatitis C ☐ Yes ☐ No
D. Tuberculosis ☐ Yes ☐ No

Has s/he ever been in an inmate (confined to lockup, jail, or prison?) for an extended period? ☐ Yes ☐ No
When and how long? _____

Did s/he ever receive blood transfusions or blood products? ☐ Yes ☐ No
When and why? _____

Was s/he ever been refused as a blood donor or told not to donate? ☐ Yes ☐ No
When and why? _____

Did s/he have any history of:
A. Heart disease ☐ Yes ☐ No
B. High blood pressure ☐ Yes ☐ No
C. Chest pain ☐ Yes ☐ No
D. Varicose veins or poor circulation ☐ Yes ☐ No

Did s/he have any kidney related disease(s) and/or dialysis treatments? ☐ Yes ☐ No
List type, when, and how long:_____

Did s/he have a history of diabetes? ☐ Yes ☐ No
List type, how long, and name of medication: _____

Did s/he have a history of the following?
A. Digestive or intestinal problems ☐ Yes ☐ No
List type, how long, and treatment _____
B. Bloody stools ☐ Yes ☐ No
C. Recent weight loss/gain: ☐ Yes ☐ No
How much? _____

Did s/he ever use tobacco products? ☐ Yes ☐ No
Amount and length used: _____

Has s/he ever had cancer (including skin cancer)? ☐ Yes ☐ No
Type of cancer: _____ Number of years without recurrence: _____

Did s/he have a medical diagnosis of?
A. Osteoporosis ☐ Yes ☐ No
B. Arthritis ☐ Yes ☐ No
C. Broken bones ☐ Yes ☐ No
List when and location of break: _____
D. Joint replacement ☐ Yes ☐ No
List when and location of replacement: _____

Did s/he have a history of skin infections?
(i.e. leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases?) ☐ Yes ☐ No
List type, location, when, and treatment: _____

In the past 12 months, has s/he ever been treated for any sexually transmitted disease?
(i.e. syphilis, gonorrhea, genital herpes, or venereal warts) ☐ Yes ☐ No
List type, when, and treatment: _____

Did s/he have a history of diseases, infections, or surgeries involving the eyes ☐ Yes ☐ No
(i.e. glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery)
List type, how long, treatment, and reason for surgery: _____

Did s/he suffer from any type of neurological or brain disease such as: For "yes" responses, please provide explanation
A. Alzheimer's or other dementia ☐ Yes ☐ No
B. Encephalitis ☐ Yes ☐ No
C. Parkinson's ☐ Yes ☐ No
D. Degenerative Neurological Disease ☐ Yes ☐ No
E. Multiple Sclerosis (MS) ☐ Yes ☐ No
F. ALS (Lou Gehrig's Disease) ☐ Yes ☐ No
G. Brain tumor ☐ Yes ☐ No
H. Seizures ☐ Yes ☐ No
I. Creutzfeldt-Jakob Disease (CJD) ☐ Yes ☐ No
J. Periods of confusion, memory loss, or hallucinations ☐ Yes ☐ No
K. Unsteady walking or visual changes ☐ Yes ☐ No
L. Clinical Depression ☐ Yes ☐ No
M. Bi-Polar Disorder ☐ Yes ☐ No
N. Schizophrenia or psychosis ☐ Yes ☐ No
O. ADD or ADHD ☐ Yes ☐ No
P. Treated in a psychiatric facility in the past two years ☐ Yes ☐ No
Facility name, reason, and when: _____

*FEMALE DONORS ONLY
Has she ever had any of the following?
Hysterectomy ☐ Yes ☐ No
Tubal ligation ☐ Yes ☐ No
Cesarean section ☐ Yes ☐ No
Bladder surgery of any kind ☐ Yes ☐ No
Type? _____

Additional Comments: _____