Anatomical GIFT PROGRAM

General Information & Donor Consent Form

Please complete this form and return to the Anatomical Gift Program, Elon University, School of Health Sciences, 2085 Campus Box, Elon, NC 27244. **PLEASE PRINT LEGIBLY. THIS INFORMATION IS USED TO FILE A DEATH CERTIFICATE.** Thank you.

Print or type donor's legal name:

First Name: Middle Name: Last Name (*and suffix if pertinent*)

Preffered name (AKA) and Pronouns:

Gender: ☐ Male ☐ Female ☐ Non-binary

I hereby make this anatomical gift to take effect upon my death. I understand that by this gift, I donate the remains of my body to Elon University's Anatomical Gift Program for anatomical study in the advancement of health sciences education, biological health sciences, and research or to a North Carolina intitution of higher learning that has been approved by Elon's Anatomical Gift Program and that is aligned with our standards of respect, dignity and compassion. This gift is made in accordance with the Revised Uniform Anatomical Gift Act, G.S. §130A-412.3 et seq. and as authorized by North Carolina state law, and will be used at the discretion of the Anatomical Gift Program.

County/State of Donor's Birth: Date of birth: Age:
Month/Day/ Year

Address:

Donor's Current Address: City:

State: County: Zip Code: Inside city limits: ☐ Yes ☐ No

Donor's Phone Number: Donor's Email:

Marital Status: Spouse's Name (name at birth):

Mother's Name (First, middle, last): Mother's name prior to marriage:

Father's Name (First, middle, last)

Race (White, African American/Black, Asian, Native American, multiracial, other)

Hispanic Origin: ☐ Yes ☐ No if yes, specify country (Cuban, Mexican, PR, etc.)

Education completed (1-12): College (1-4): Other:

Served in U.S. Armed Forces: ☐ Yes ☐ No

Usual Occupation (prior to retirement): Business/Industry:

Donor's Social Security Number:

Contact Name (or next-of-kin): Relationship to Donor:

Contact Address: City: State: Zip:

Contact's Phone Number: Contact's Email:

CONSENT

I have read the information about body donations provided by Elon University's Anatomical Gift Program and/or the AGP Brochure. I understand and accept the following:

- I am donating my body to Elon University's Anatomical Gift Program for healthcare education and research. The programs of study of my body will be determined by the Anatomical Gift Program.
- I understand that my body may teach at an accredited and fully vetted North Carolina health sciences institution and shall return to Elon University's Anatomical Gift Program for cremation and disposition.
- The information I have provided in General Information is true and correct and will be used to file a death certificate at the time of my death providing my body is accepted by the Anatomical Gift Program.
- I understand that the information I have provided is voluntary and the Health History Questionnaire will be shared with faculty in undergraduate biosciences, Doctor of Physical Therapy, Occupational Therapy and Physician Assistant Studies programs and their students.
- I understand that my Social Security number will be used for verification and death certificate purposes only and will be securely retained.
- The Anatomical Gift Program (AGP) reserves the right to decline any donation including for the reasons listed in the information pages. If the body is declined, the Anatomical Gift Program will not accept financial responsibility for the disposition of the body.
- I understand that studies can range typically from 2 to 3 weeks up to 3 years in length.
- I understand that photographs of my body may be taken in the anatomy labs of the McMichael Science Building and the Gerald L. Francis Center, which will be permitted for teaching and research only as directed by the respective course instructor.
- I understand that the Anatomical Gift Program will administer a serology test to determine contagious diseases such as: COVID-19, HIV/AIDS, hepatitis B, hepatitis C, and West Nile Virus. If the test is reactive (positive), I understand that my body will be cremated at the expense of the Anatomical Gift Program.
- I authorize the Anatomical Gift Program to cremate my remains consistent with the G.S, 90-210.120. et seq., as I have designated below.

LONG TERM RETENTION

I give the Anatomical Gift Program permission to retain an organ/or body part(s) for long term anatomy research, teaching, and/or permanent preservation such as the recreation of skeletal materials for curricular topics. I understand the rest of my body will be cremated as I have instructed in the Donor Consent Form.

Donor Name (printed): _____

Donor's Signature: _____

Date: _____

Day/ Month/ Year

Form continues on reverse side.

ALL ashes will be returned to family or designee.

Designation of Ashes (please make one selection):

☐ I direct that my ashes be returned to one of the individuals listed below (a-c) with priority given according to the order in which they are listed. Only those individuals listed below will be allowed to receive ashes. If the AGP is unable to contact any of the listed individuals, the ashes will be stored in a secured area in the Elon University School of Health Sciences for two years and if the ashes are unclaimed by the end of two years, they will be disposed of compliant with the North Carolina General Laws **§ 90 210.130. Final disposition of cremated remains.** Distribution by the AGP to individuals other than those named by the donor will require a lawful court order so ordering the University.

a) Recipient Name: _____ Phone: ( )

Relationship to Donor: _____ E-mail: _____

Street: _____ City: _____ State: _____ Zip: _____

b) Alternate Recipient 1 Name: _____ Phone: ( )

Relationship to Donor: _____ E-mail: _____

Street: _____ City: _____ State: _____ Zip: _____

c) Alternate Recipient 2 Name: _____ Phone: ( )

Relationship to Donor: _____ E-mail: _____

Street: _____ City: _____ State: _____ Zip: _____

ALL DONOR REGISTRANTS MUST COMPLETE THIS PORTION OF THE FORM:

Donor Signature: _____ Date: _____ Day/ Month/ Year

Phone: ( )

Street: _____ City: _____ State: _____ Zip: _____

County: _____ Donor E-mail: _____

First Witness

Print name: _____

Signature: _____

Street: _____

City, State, Zip: _____

Date: _____

Second Witness

Print name: _____

Signature: _____

Street: _____

City, Sate, Zip: _____

Date: _____

The Anatomical Gift Program is under no obligation to accept an anatomical gift and reserves the right to decline any donation.

Anatomical GIFT PROGRAM

Health History Questionnaire

The information provided is voluntary. The Health History Questionnaire will be shared with faculty in undergraduate biosciences, Nursing, Doctor of Physical Therapy, Occupational Therapy and Physician Assistant Studies programs and their students.

COVID-19 NOTIFICATION: Please visit www.elon.edu/anatomical-gift for a complete update on our COVID-19 protocols. Thank you.

Donor Legal Name: Today's Date:

GENERAL PATIENT INFORMATION

In general, how do you describe the quality of your health?

☐ Outstanding ☐ Good ☐ Some chronic issues ☐ Poor

Do you exercise?

☐ Sedentary (no exercise) ☐ Occasional vigorous (30 min. 2x/wk)

☐ Mild exercise (walk, golf) ☐ Regular vigorous (30 min. 4x/wk)

Donor's current weight: Donor's current height:

What is your caffeine intake?

☐ No caffeine ☐ # of caffeinated drinks per day

Do you use tobacco?

☐ Cigarettes: packs/day ☐ Chew: #/day ☐ Pipe: #/day ☐ Cigars: #/day

PERSONAL HEALTH HISTORY

Childhood illnesses:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken pox ☐ Rheumatic fever ☐ Polio

List any medical problems that doctors have diagnosed:

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever been treated with Human Growth Hormones? ☐ Yes ☐ No

Have you undergone brain surgery for head trauma or brain cancer? ☐ Yes ☐ No

Have you ever received a cornea transplant? ☐ Yes ☐ No

Have you been rejected to donate blood? ☐ Yes ☐ No

If yes, why?

COVID-19:

ALL QUESTIONS MUST BE ANSWERED

Have you been diagnosed or infected with COVID-19? ☐ Yes ☐ No If yes, please provide dates:

Have you received the COVID-19 vaccine? ☐ Yes ☐ No If yes, please provide dates of the first and second injections:

If no, do you plan to receive the COVID-19 vaccine? ☐ Yes ☐ No If so, when?

SURGERIES AND OTHER HOSPITALIZATIONS:

Please list and date your surgeries:

Do you have a radioactive medical impant? ☐ Yes ☐ No Date and location of implant:

Please list and date other hospitalizations:

WOMEN ONLY

Have you had a hysterectomy or Cesarean? ☐ Yes ☐ No

Thank you for taking the time to complete this questionnaire. We pride ourselves on first patient approach and creating a culture of respect. The information you have provided will be kept in your donor registration file maintained in a secured environment in the Anatomical Gift Program office. The information you have provided will be most useful for informing faculty and students from higher learning institutions affiliated with the Anatomical Gift Program. This document will be shared with authorized Elon University faculty and students. and authorized faculty and students from vetted institutions of higher learning approved of by the Anatomical Gift Program. Certain answers may cause the need for your Health Care Practitioner to complete a follow-up form. Are you open to this? ☐ Yes ☐ No Donor's initials here: _____

Please take a few more minutes and tell us (below) what anatomical donation means to you. The noble gift of donating one's body after death is an important decision. All of us in the Anatomical Gift Program at Elon University respect and honor your decision. We thank you for the unique learning experience.

Dianne Person, Director

We value the importance of treating the "whole" patient: mind, body and soul. In this regard, we wish to know HOW and WHY you chose the Anatomical Gift Program at Elon University. Please tell us the name you would like us to use when you serve as our "silent teacher." Please be sure to answer ALL questions. Thank you.

- 1. **(PLEASE ANSWER BOTH QUESTIONS)** WHAT WOULD YOU LIKE TO SHARE WITH OUR STUDENTS WHO WILL BENEFIT FROM YOUR GIFT? 2. HOW DID YOU CHOOSE ANATOMICAL DONATION AT ELON?

- ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A CLIENTS TO CLASS PATIENT AT ELON'S SCHOOL OF HEALTH SCIENCES? IF YES, PLEASE PROVIDE THE DATES AND THE NAME OF THE STUDENT(S) YOU WORKED WITH.

- DONORS MAY CHOOSE TO REMAIN ANONYMOUS OR SELECT USE OF THEIR FIRST NAME, OR SURNAME FOR USE BY FACULTY AND STUDENTS WHO WILL WORK WITH THEM. **PLEASE WRITE YOUR CHOICE HERE**:

Would you like someone to contact you regarding your responses on this survey? ☐ Yes ☐ No