

This form should be completed as soon as possible after receipt by the next-of-kin or person lawfully responsible for the body of the deceased. The information you provide in this questionnaire is utilized to determine if your loved one will be designated for teaching or research within Schulich School of Medicine & Dentistry.

**You may complete this form and mail it back to this office – OR – scan the QR code below and complete the form online**



Name of the deceased: \_\_\_\_\_

What were the preferred gender pronouns of the deceased? (ie. She/her, he/him, they/them)

\_\_\_\_\_

What was the Cultural Identity & Ethnicity of the deceased? (ie. First Nations, Asian, White, Black, etc.)?

\_\_\_\_\_

**1) Schulich School of Medicine & Dentistry, Western University will arrange for the cremation of the donor once the study has been completed. Typically, cremation occurs between 18-36 months after receiving the donor into our care. Please indicate your wishes regarding the cremated remains below with a check mark.**

I **do wish** to claim the cremated remains once the school has completed their course of study.

I **do not wish** to claim the cremated remains. I would prefer that the school arrange for burial.

**2) Do you wish to receive an invitation to Schulich School of Medicine & Dentistry, Western University's annual memorial service honouring our donors?**

- Yes, I wish to receive an invitation to a service honouring the donation of the deceased.
- No, I do not wish to receive invitations to a service. I understand that I will not receive any further correspondence regarding the deceased.

**3) Schulich School of Medicine & Dentistry occasionally uses cadaveric material kept for long term retention to aid in its educational mission. The ultimate disposition of this retained material is cremation, followed by interment in the University burial site with similar remains.**

**Do you grant permission for the school to keep specimens of interest from the body of the deceased donor?**

- Yes, I give my permission as the next of kin or executor of the estate of the deceased for Schulich School of Medicine & Dentistry, Western University to retain some cadaveric material of the deceased for an indeterminate time for educational purposes.
- No, I do not give my permission for Schulich School of Medicine & Dentistry, Western University to retain parts of the body of the deceased.

**4) To your knowledge, did the deceased have any of the following medical interventions?**

	Yes	No
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Implantable Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic Joint Replacement If yes – please describe	<input type="checkbox"/>	<input type="checkbox"/>
Brachytherapy (radioactive inserts typically used to treat Prostate Cancer)	<input type="checkbox"/>	<input type="checkbox"/>

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**Please provide your contact information as the executor or next of kin of the deceased donor.**

Name: \_\_\_\_\_ Relationship to the deceased: \_\_\_\_\_  
PLEASE PRINT

Complete Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Witness Signature: \_\_\_\_\_  
WITNESS CAN BE ANY PERSON THAT WITNESSES THE NEXT OF KIN'S SIGNATURE WHO IS NOT THE NEXT OF KIN

**In some instances, it is helpful to have the contact information of an additional person for future correspondence. Please provide complete contact information of a designated person.**

Name of Secondary contact: \_\_\_\_\_  
Relationship to the deceased: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

