Schulich
MEDICINE & DENTISTRY

Anatomy & Cell Biology

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.)?

_____

Schulich School of Medicine & Dentistry, Western University
Medical Sciences Building, Room 443, London, ON, Canada N6A 5C1
Telephone: (519) 661-3014, Fax: (519) 661-3936, www.uwo.ca/anatomy

Western

1) **As the Estate Trustee, Estate Administrator or Next-of-kin of the deceased, which of the following statements best capture the spirit of the donation.**

- ☐ The deceased completed and signed Western University's Body Bequeathal Program Form A regarding the donation of their body
- ☐ The deceased explicitly made known to me or others their wish to be donated to a School of Anatomy
- ☐ The deceased implied during their lifetime that donation to science was a preferred option for disposition
- ☐ I have made the decision for body bequeathal based on my understanding of the deceased's values and intentions
- ☐ I am making the decision to donate the deceased based upon my own values and intentions

2) **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.

3) **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.

4) 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.

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

	Yes	No
Pacemaker	☐	☐
Implantable Defibrillator	☐	☐
Prosthetic Joint Replacement If yes – please describe	☐	☐
Brachytherapy*	☐	☐

*Brachytherapy is a form of radiation therapy where a sealed radiation source is placed inside or next to the area requiring treatment. Brachytherapy is used as treatment for cervical, prostate, breast, esophageal and skin cancer and can also be used to treat tumours in many other body sites.

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: _____

Please share with us any information you think may be useful to the students/researchers regarding past illnesses, surgeries, lifestyle factors or other medical issues the donor may have had. We love to hear about the lives of our donors. **For example, we love to hear the stories behind tattoos and scars, if they loved gardening, motorcycles or board games, if they were happiest in quiet reflection or surrounded by a party. These details help our students understand and appreciate our donors as individuals.**

Any information you provide about the biography or health history of your loved one will be anonymized and shared with select students.

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