Icahn School of Medicine at Mount Sinai

Anatomical Gift Program (~~Whole Body Donation~~)
One Gustave L. Levy Place, Box 1007, Annenberg Suite 12-90
New York, NY 10029-6574
Telephone: 212-241-7276 Fax: 212-860-1174
Website: www.icahn.mssm.edu/bodydonation

Thank you for your request for information concerning our Anatomical Gift Program.

To Register as a Whole Body Donor complete the following 2 forms and submit the original forms to the Coordinators of the Anatomical Gift Program at the address above.

Bequeathal form. The Donor in the presence of one or more witnesses, who is at least 18 years of age, must sign this form. Please make multiple copies of the Bequeathal form and distribute as indicated on the bottom of the form, or to any person the Donor wishes to have knowledge of his/her decision.

The Donor must have a next of kin or an executor of is/her will to qualify for this program.

Information form #1. The Donor completes the questions 1-17.

Completing & submitting the 2 forms stated above concludes the registration process for the Anatomical Gift Program at the Icahn School of Medicine at Mount Sinai.

The following 4 forms need to be completed by the next of kin and/or the Executor of the will *after* the Donor expires.

Information form #2. The next of kin and/or the executor of the will completes questions 18-30.

Medical School Affidavit. The next of kin and/or the executor of the will completes the form and signs the form in the presence of a notary public.

An Application for Cremation Permit. This form also is to be completed by the next of kin and/or the executor of the will and signs the form in the presence of a notary public.

Remains to Family form. The next of kin and/or the executor of the will documents the Donor's wishes regarding the disposition of ashes.

Upon completion of the above 4 forms, the originals must be submitted to the Program Coordinators.

When death occurs, the next of kin or Executor of the will should *immediately* notify the Anatomical Gift Program Coordinators by calling (212) 241-7276. If it is outside of normal business hours, the Coordinators can be ***PAGED* by dialing (917) 641-0063 or (917) 641-0094. After hearing a series of beeps, dial a return call back number.** We will return the page as soon as possible to gather the Donor information and make the necessary arrangements with our Funeral Directors to transport the Donor.

As of January 1st 2020 our Anatomical Gift Program has implemented new fees. The cost of each death certificate is **$15.00**, along with the one-time processing fee of **$250.00** for a **registered donor**. The processing fee for an **unregistered donor** is **$350.00**. If you wish to have the **cremains** mailed to you or interred by the medical school in our cemetery plot the fee is **$100.00**. There are no fees charged should you decide to pick up the **cremains** from our office.

PLEASE NOTE: We will not accept a body that has been autopsied/embalmed. We will also not accept the remains of someone who has had an active communicable disease at the time of death. We also reserve the right to not accept a body if over 250lbs.

SIGNATURE DATE

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BEQUEATHAL FORM

Being of sound mind and over the age of 18, I hereby make this anatomical gift of my body to the Icahn School of Medicine at Mount Sinai (hereafter abbreviated ISMMS) in the City of New York, to take effect upon my death. I direct that after my death my body be delivered to the ISMMS at Fifth Avenue and 100th Street, New York City, for medical education, research and any other purpose authorized by law. I understand that the ISMMS will pay for the cost of transportation of my body to the School, up to a distance of 20 miles. The agent of the ISMMS will cremate the remains of my body.

If the Icahn School of Medicine at Mount Sinai is unable to accept my body (due to autopsy, because my Next of Kin/Executor do not agree to pay transportation costs in the excess of 20 miles, or if I die outside of the United States, or for any other reason) I hereby direct my Next of Kin/Executor to offer my remains to the nearest medical school to be used for the purpose stated above.

Date: _____

Name of Donor:(Please Print Clearly) _____

Name of Deceased Donor: (Please Print Clearly)_____

Address: _____

Apt#:_____City:_____State:_____Zip:_____

Telephone and/or Cell Numbers:_____

Social Security Number: _____Date of Birth:_____

SIGNED BY the DONOR in the presence of one or more who sign as Witnesses:

OR

SIGNED BY NEXT of KIN/EXECUTOR for DECEASED DONOR in the presence of one or more who sign as Witnesses:

_____
Signature of DONOR

_____
Signature NEXT of KIN/EXECUTOR
FOR DECEASED DONOR

_____
Signature of Witness

_____
Signature of Witness

_____
Address of Witness

_____
Address of Witness

Revised July 2021

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Information Form (Page 1)

1. Full Name of Donor: _____ (Please Print Clearly)
2. Please list other name(s) by which the Donor is known:

   _____
3. Address: _____

   Apt #_____ City: _____ State: _____ Zip: _____

   Telephone Numbers (Home/Work/Cell): _____
4. Date of Birth: Month _____ Day _____ Year _____
5. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
6. Birthplace (City/State, and/or Foreign Country): _____
7. Full Name of Spouse/Partner: _____ (If wife, please give full maiden name)
8. Occupation During Working Period: _____
9. Level of Education Achieved: _____
10. Type of Career/Business or Industry: _____
11. Social Security Number: (Please Print Clearly) _____
12. United States Veteran: ☐ Yes ☐ No ☐ N/A
13. Full Name of Donor's Father _____
14. Full Name of Donor's Mother (Maiden) _____
15. Name of Next of Kin and/or Executor of the Will: _____
16. Please specify ***your*** Relationship to the Donor: _____
17. Address for the Next of Kin and/or Executor: _____

    Apt #_____ City: _____ State: _____ Zip: _____

    Contact Numbers (Home/Work/Cell): _____

    _____ Email Address: _____

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Information Form (Page 2) -To be completed *after* the Death of the Donor.

18. Date of Death: Month _____ Day _____ Year _____

19. Place of Death (Institution/Hospital/Home): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

20. Length of time in NYC prior to death: _____

21. Age at last birthday: _____ 22. Citizen of what Country: _____

23. Full Name of Informant: _____

24. Relationship to the Deceased: _____

25. Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Contact Numbers (Home/Work/Cell) _____

26. Full Name of the Person Authorizing Donation: _____

27. Relationship to the Deceased (Next of Kin or Executor of the Will): _____

Address: _____

Apt # _____ City: _____ State: _____ Zip: _____

Contact Numbers (Home/Work/Cell): _____

28. If the Donor's spouse is deceased, please indicate the Date of Death _____

29. Name of the Deceased Attending Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

30. Total Number of Death Certificates Requesting: _____

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VR 50 (REV 8/02) APPLICATION FOR CREMATION PERMIT

To the Office of Vital Records,
Department of Health and Mental Hygiene,
The City of New York

State _____

COUNTY OF _____ SS:

_____ being duly sworn deposes and states

that he/she resides at _____
(Address)

and desires that a permit be issued by the Department of Health and Mental Hygiene of the City of New York for the cremation of the body of _____
(Donor's Name)

who died at _____
(Address)

On _____.
(Date)

Deponent's assumption of authority to act is based upon the following:

Deponent further states that the deceased did express during life the desire to have his/her remains cremated and his/her relationship to deceased is:

_____.

Subscribed and sworn to before me this _____ day of _____
(Date) (Month) (Year)

✖ _____
Signature of Next of Kin or Executor of the Will

✖ _____
Signature of Notary Public

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MEDICAL SCHOOL AFFIDAVIT

State of _____

County of _____

I, _____, residing at

_____, depose and say that I am the

_____Next of Kin and/or the Executor of the Will for
(Relationship)

_____
(Deceased Donor-Please Print)

And that it is my desire to carry out the wish of said _____
(Deceased Donor)

That his/her remains be delivered to the Department of Medical Education of the Icahn School of Medicine at Mount Sinai for use in teaching and for the promotion of Medical Science and Research.

In the event that the remains of the said_____
(Deceased Donor)

are held at the City Mortuary, or similar authority, I hereby authorize the City Mortuary, or said similar authority, to release the remains to the designated agents of Icahn School of Medicine at Mount Sinai for delivery to the Department of Medical Education.

When the remains of the said _____ cease to be of
(Deceased Donor)

value to the Icahn School of Medicine for said purpose, I authorize that the remains be cremated with the Laws of the State of New York at no cost to the family or estate of the Deceased, in agreement with the wishes of the Deceased.

✖_____
Signature of Next of Kin or Executor of the Will

Sworn to before me this_____ day of _____, year_____.

✖_____
Signature of Notary Public

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REMAINS TO FAMILY FORM

Date: _____

As the Next of Kin or Executor of _____,
(Donor's Name/Please Print Clearly)

☐ **I request that the ashes be returned to:**

Name: _____
(Designated Recipient)

Address: _____

Apt #_____City: _____ State: _____ Zip: _____

Contact Numbers (Home/Work/Cell): _____

Email: _____

I understand that if the Anatomical Gift Program at the Icahn School of Medicine at Mount Sinai is unable to contact the Designated Recipient at the number and/or addresses above, within six months of notification, the remains will be interred at The Brick Church Cemetery, in Spring Valley, New York.

☐ **I request that the ashes be interred at The Brick Church Cemetery.**

✖_____
(Signature)

_____
(Print Name Clearly)