



DONALD AND BARBARA
ZUCKER SCHOOL of MEDICINE
 AT HOFSTRA/NORTHWELL

Registry of Intent for Whole Body Donation

(to be completed by the prospective donor)

Being of sound mind and at least 18 years of age, I, _____, direct that immediately upon my death, my whole body (or any part thereof) be made available for educational and/or research purposes to the Whole Body Anatomical Gift Program ("Gift Program") of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell. In so doing, I give permission for embalming of my body as needed for study.

I have read the Gift Program documentation and agree to abide by its procedures and policies regarding whole body donation. I understand that there are certain circumstances that may preclude a donation from being accepted, as described in the Gift Program documentation. I acknowledge that it is my responsibility, or the responsibility of my legally authorized representative, to make alternative arrangements for the disposition of my body in case it is not accepted by the Gift Program.

I authorize the Gift Program to transfer my remains to another institution legally authorized to receive anatomical gifts in the event that the purpose of medical education and/or research would be best served by this action. I understand that anatomical studies generally take between one and three years, and that some portions of donations may be retained for longer periods of time for archival purposes.

Should my death occur within the county of Nassau or Suffolk, or one of the five boroughs of the City of New York (Bronx, Brooklyn, Manhattan, Staten Island, Queens) (defined as the "donation area"), I request that the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell be designated to carry out my direction in accordance with its donor procedures and policies. In this case, notice should be given no later than 24 hours following my death by contacting the Gift Program at 516-463-7505.

Should my death occur outside of these areas, I direct that: **(Check ONE of the following two statements.)**

_____ My body be made available to the nearest medical school, and my executor be authorized to pay transportation costs from my estate.

_____ My body be transported to the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell at the full expense of my estate.

I authorize that my remains be cremated at a licensed in-state crematory at the conclusion of anatomical studies at the expense of the Gift Program. After cremation, I request that my remains be: **(Check ONE of the following two statements.)**

_____ Scattered at sea.

_____ Returned to the person listed below who will assume responsibility for them. **The remains should be made available to: (Please print.)**

Name: _____ Relationship to donor: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Phone: _____ - _____ - _____ Email: _____

I agree to the above conditions and the policies and procedures of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Whole Body Anatomical Gift Program. This form must be signed by a witness.

Printed Name (Donor): _____

Address: _____ City: _____ State: _____ ZIP code: _____

Email: _____

Signature of Donor: _____ Date: _____

Witness

Printed Name: _____ Relationship to donor: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Email: _____

Witness Signature: _____ Date: _____

500 Hofstra University, Hempstead, NY 11549-5000 • DONOR PROGRAM PHONE: 516-463-7505 • FAX: 516-463-5097
 EMAIL: cira.peragine@hofstra.edu • WEB: medicine.hofstra.edu/agp

White: Return to Gift Program

Yellow: Donor

Pink: Next of Kin/Authorized Representative