TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Institute *of* Anatomical Sciences
Willed Body Program

3601 4th Street STOP 6528
Lubbock, Texas 79430-6528
T 806.743.2708 | F 806.743.9455
WBP.Lubbock@ttuhsc.edu

NEXT OF KIN
DONATION FORM
(Please Print or Type)

Mr. ☐
Ms. ☐
Mrs. ☐
I, *Miss* ☐ _____ (Name), _____ (Relationship)

as next of kin of _____, do hereby give and grant the body of said deceased to the State Anatomical Board of as represented by the Texas Tech University Health Sciences Center Institute of Anatomical Sciences Willed Body Program (TTUHSC-IAS-WBP) for medical teaching and research purposes, and I do hereby grant and direct the

_____ to deliver said body to the TTUHSC-IAS-WBP.
(Funeral Home or Transport Service)

I understand that cremation is the final disposition of the remains of the donated body. I as the next of kin or executor of the estate of the donor can request the return of the residual cremated remains this request must be made in writing by completing the provided Return of Cremated Remains Form at the time of death when the donation is initiated. I understand that the policy of the TTUHSC-IAS-WBP is that cremated remains of individuals that **are not requested for return in writing** are irretrievably co-mingled when buried in TTUHSC- IAS- Willed Body Program ossuary.

I hereby relinquish all rights and claims regarding said body and direct that by accepting and using this body for teaching and scientific purposes and its subsequent disposition, neither the SAB, nor any receiving institution, shall incur any liability, and no manner of claim shall arise against the SAB or a receiving institution. I authorize the SAB to transport the willed/donated body hereon described out of the State of Texas in the event that the holding institution and the secretary-treasurer of the SAB have determined that an excess of bodies currently exists in the State of Texas.

WITNESS MY HAND THIS _____ DAY OF _____, 20_____.

Deceased Social Security # _____ - _____ - _____ Date of Birth ___ / ___ / ___ Date of Death ___ / ___ / ___

Signed: _____ Signed: _____

Relationship: _____ Relationship: _____

Phone#:(_____) _____-_____ Phone#:(_____) _____-_____

Address: _____ Address: _____

_____ _____

WITNESSED BY: _____ Address: _____
(Anyone 18 years or older, including relatives)

_____

WITNESSED BY: _____ Address: _____
(Anyone 18 years or older, including relatives)

_____

Complaints or inquiries regarding a willed or donated body should be directed to the secretary-treasurer of the SAB. The name and address of this individual may be obtained from the institution to which the body was delivered and is listed in the Texas State Telephone Directory.

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PERSONAL DATA FORM
(Please Print or Type)

Social Security #:_____ Date:_____

Full Name: _____
first middle last maiden name (if applicable)

Address: _____
street city state zip

Email:_____ Telephone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Place of Birth: _____
Month day year city county state

Individuals Education (Check the box that best describes the highest degree or level of school completed)

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

Individual of Hispanic Origin? (Check the box that best describes you, Spanish/Hispanic/Latino. Check the "no" box if you are not Spanish/Hispanic/Latino)

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino
- ☐ (Specify) _____

Individual's Race (Check one or more races to indicate what you consider yourself to be)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ (Name of the enrolled or principal tribe)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify)_____
- ☐ Other (Specify)_____

Ever in the Armed Forces? ☐ yes ☐ no

Ever a Peace Officer in this State? ☐ yes ☐ no

Usual Occupation (Indicate type of work done during most of working life. DO NOT USE RETIRED)

Type of Business/Industry

Marital Status: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced

Spouse: _____
first middle last (included maiden name if applicable)

Please list parent's names, even if deceased.

Father's Name: _____
first middle last

Mother's Name: _____
first middle maiden name

For Notification:
Immediate Next of Kin:_____ Relationship:_____

Address: _____
street city state zip

Email:_____ Telephone: _____

Veterans -- Please complete the following

Branch of Service:_____ Military Rank:_____ Military Unit: _____

Military Serial Number:_____ Entry Date:_____ Discharge Date:_____ Type of Discharge: _____

Please keep this information current with our office
Please complete & return with white copy of Donation Form

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(COMPLETE AND RETURN)

The Willed Body Program Cremation Form

The normal procedure for disposition of the bodies upon completion of Anatomical Studies is cremation.

If this form is not returned, the next of kin or executor relinquish their rights to the cremated remains.

Please *Initial* next to your decision and sign/complete the information below

_____ **I DO NOT** wish cremated remains to be returned. Texas Tech University Health Science Center will arrange for the proper disposition of the cremated remains by irretrievably co-mingling them in their ossuary.

OR

_____ **I WISH** the cremated remains to be returned. Contact will be made by letter or telephone, at the time of cremation to arrange for the return of the cremated remains on average between 14 to 24 months from the date of death. The cremated remains are normally returned via U.S. Postal Service, Priority Mail Express, Return receipt requested.

Signature of Next – Of - Kin Date

Print Name of Next – Of - Kin Relationship

Address

City, State, Zip Code Phone: (Home) (Work)

Complete if delivery is to another individual:

Name Address

City, State, Zip Code Phone: (Home) (Cell) (Work)

Do not write below this line

Name of Deceased SAB Number

Date of Death Date of Receipt

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Medical Assessment Questionnaire

Note: The person completing this form should answer ALL questions YES or NO, to the best of your knowledge; comment and elaborate on all questions marked YES. (Additional space for expanded comments available on page 3)

Donor Age: _____ Sex: ◯ Male ◯ Female _____ height _____ weight

Has s/he been hospitalized in the past two years? ☐ Yes ☐ No
Reason: _____

Did s/he Have any serious illnesses or infections in the past? ☐ Yes ☐ No
What type and when? _____

Have any surgical procedures in the past? ☐ Yes ☐ No
What type and when? _____

Has s/he ever been diagnosed with the following contagious illnesses?
A. HIV or AIDS ☐ Yes ☐ No
B. Hepatitis B ☐ Yes ☐ No
C. Hepatitis C ☐ Yes ☐ No
D. Tuberculosis ☐ Yes ☐ No

Has s/he ever been in an inmate (confined to lockup, jail, or prison?) for an extended period? ☐ Yes ☐ No
When and how long? _____

Did s/he ever receive blood transfusions or blood products? ☐ Yes ☐ No
When and why? _____

Was s/he ever been refused as a blood donor or told not to donate? ☐ Yes ☐ No
When and why? _____

Did s/he have any history of:
A. Heart disease ☐ Yes ☐ No
B. High blood pressure ☐ Yes ☐ No
C. Chest pain ☐ Yes ☐ No
D. Varicose veins or poor circulation ☐ Yes ☐ No

Did s/he have any kidney related disease(s) and/or dialysis treatments? ☐ Yes ☐ No
List type, when, and how long: _____

Did s/he have a history of diabetes? ☐ Yes ☐ No
List type, how long, and name of medication: _____

Did s/he have a history of the following?
A. Digestive or intestinal problems ☐ Yes ☐ No
List type, how long, and treatment _____
B. Bloody stools ☐ Yes ☐ No
C. Recent weight loss/gain: ☐ Yes ☐ No
How much? _____

Did s/he ever use tobacco products? ☐ Yes ☐ No
Amount and length used: _____

Has s/he ever had cancer (including skin cancer)? ☐ Yes ☐ No
Type of cancer: _____ Number of years without recurrence: _____

Did s/he have a medical diagnosis of?
A. Osteoporosis ☐ Yes ☐ No
B. Arthritis ☐ Yes ☐ No
C. Broken bones ☐ Yes ☐ No
List when and location of break: _____
D. Joint replacement ☐ Yes ☐ No
List when and location of replacement: _____

Did s/he have a history of skin infections?
(i.e. leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases?) ☐ Yes ☐ No
List type, location, when, and treatment: _____

In the past 12 months, has s/he ever been treated for any sexually transmitted disease?
(i.e. syphilis, gonorrhea, genital herpes, or venereal warts) ☐ Yes ☐ No
List type, when, and treatment: _____

Did s/he have a history of diseases, infections, or surgeries involving the eyes ☐ Yes ☐ No
(i.e. glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery)
List type, how long, treatment, and reason for surgery: _____

Did s/he suffer from any type of neurological or brain disease such as:
For "yes" responses, please provide explanation
A. Alzheimer's or other dementia ☐ Yes ☐ No
B. Encephalitis ☐ Yes ☐ No
C. Parkinson's ☐ Yes ☐ No
D. Degenerative Neurological Disease ☐ Yes ☐ No
E. Multiple Sclerosis (MS) ☐ Yes ☐ No
F. ALS (Lou Gehrig's Disease) ☐ Yes ☐ No
G. Brain tumor ☐ Yes ☐ No
H. Seizures ☐ Yes ☐ No
I. Creutzfeldt-Jakob Disease (CJD) ☐ Yes ☐ No
J. Periods of confusion, memory loss, or hallucinations ☐ Yes ☐ No
K. Unsteady walking or visual changes ☐ Yes ☐ No
L. Clinical Depression ☐ Yes ☐ No
M. Bi-Polar Disorder ☐ Yes ☐ No
N. Schizophrenia or psychosis ☐ Yes ☐ No
O. ADD or ADHD ☐ Yes ☐ No
P. Treated in a psychiatric facility in the past two years ☐ Yes ☐ No
Facility name, reason, and when: _____

*FEMALE DONORS ONLY
Has she ever had any of the following?
Hysterectomy ☐ Yes ☐ No
Tubal ligation ☐ Yes ☐ No
Cesarean section ☐ Yes ☐ No
Bladder surgery of any kind ☐ Yes ☐ No
Type? _____

Additional comments (please refer to question numbers when appropriate):