NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

School of Medicine

CERTIFICATE FOR BEQUEATHING BODY

Department of Cell Biology and Anatomy
Valhalla, NY 10595
(914) 594-4025

☐ **I hereby bequeath and donate my own body, following my death, without autopsy or embalming, to New York Medical College, for medical study and research.**

OR

☐ **I hereby direct that the body of _____ recently deceased, be delivered to New York Medical College, for medical study and research. Such delivery is to be made without autopsy or embalming.**

PROCEDURE AT TIME OF DEATH: New York Medical College must be contacted to arrange transportation. The telephone number to call is:

(914) 594-4025 or (845) 735-4849

ALTERNATIVE ARRANGEMENTS: The College has the right to decline a donation due to recent surgery, autopsy, infectious disease, decomposition, or obesity.

DISPOSITION OF THE REMAINS: New York Medical College will arrange for cremation of the remains. Cremains may be returned to a next-of-kin, or to a funeral director. If you so choose, the cremains may be interred in the medical school's crypt in Femcliff Cemetery, in Hartsdale, NY.

Name _____ **Relationship to Donor** _____
(Print) **(i.e. self, spouse, etc.)**

Address _____

City/State _____

Signature _____ **Dated** _____

Witness _____ **Witness** _____
(Print) **(Print)**

Address _____ _____

City/State _____ _____

Signature _____ _____

Dated _____ _____

Body Bequeathal Program - Confidential Statistical Information
New York Medical College
Department of Cell Biology and Anatomy
Valhalla, NY 10595

Name:		
Present Address:		
Telephone Number:	Social Security No.:	
Date of Birth:	Place of Birth:	
Medicaid Number:	Sex: Female / Male	Race:
Are You a US Citizen? YES / NO If No, Please Specify:	Are You of Hispanic Origin? YES / NO If Yes, Country of Origin:	
Father's Name:	Mother's Name: _____ (Include Maiden Name)	
Your Occupation (Prior to Retirement): _____ Name of Business: _____ Type of Business: Location:		
War Veteran: NO / YES - War Served: Dates Served: From: To:		Last School Grade Completed
Marital Status:	Spouse's Name: _____ (For Wife, Include Maiden Name)	
Spouse's Address & Telephone Number (If Different From Yours):		
Name of Closest Relative: _____ Address: _____ Telephone Number: _____ Relationship to You: _____		
Request For Ashes To Be Returned ☐ YES ☐ NO Ashes will be available for return approximately 2 years from the time of death If ashes are to be returned, please complete the following: Name of Individual to Receive Ashes: _____ Address: _____ Telephone Number: ( ) __ _____-_____Relationship To Donor:		
Other Arrangements for Remains (explain):		
_____ Signature Date		