Anatomical Gift Pledge Form

Please return this completed form to the address listed below or in the envelope provided. You will receive a donor card for your wallet.

This statement is to certify that I wish at the time of my death, shall I meet the program criteria for acceptance, to be transported and delivered to the Anatomical Gift Program at SUNY Upstate Medical University to be used as an unrestricted gift to help further medical advancements and education.

In connection with this pledge, I have received and reviewed the Anatomical Gift Program brochure and understand its contents. I have had any questions fully answered and understand that I must meet the program requirements (height, weight, infectious-contagious-communicable disease exclusions, etc.) at the time of my death. I understand that a pledge to donate does not guarantee acceptance and that it may be necessary for another choice of disposition should the program be unable to honor my wish.

I understand that this donation may be provided for use by an institution of higher education in New York State in which Gross Anatomy is an integral and required component of an accredited program to educate health professionals and allied health professionals, provided the institution is licensed by the New York State Department of Health as a whole body user.

I understand that a portion of my donation may be retained for archival purposes.

I acknowledge that I meet the Program criteria for donation of my body. (as noted in the Q&A section of the brochure)

Donor's signature: _____

Donor name *(please print)*: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss _____

Date of pledge: _____ Donor's Weight: _____ Donor's Height: _____

Donor's Social Security number: ☐☐☐ - ☐☐ - ☐☐☐☐ Donor's date of birth: _____

Donor's present address: _____
street *city* *state* *zip*

Donor's phone number: ☐☐☐ - ☐☐☐ - ☐☐☐☐
area code

Witness signature: _____

Witness address: _____
street *city* *state* *zip*

Witness phone number: ☐☐☐ ☐☐☐ ☐☐☐☐
area code

Please return completed forms to:

Department of Cell and Developmental Biology
SUNY Upstate Medical University
Anatomical Gift Program
750 E. Adams St., Rm 1133WH
Syracuse, NY 13210

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INCOMPLETE FORMS WILL BE RETURNED

Return of Cremains

☐ **Please check this box if cremains are NOT to be returned.**

For return of cremains, please fill out that information below.

Donor name *(please print)*: _____

Name of person or institution to whom cremains should be delivered:

_____

Address: _____

_____
city *state* *zip*

Phone number: ☐☐☐ - ☐☐☐ - ☐☐☐☐
area code

Relationship to Donor: _____

Correspondence

To whom should all correspondence be directed after death:

☐ Check here if information above is the same.

Name *(please print)*: _____

Address: _____

_____
city *state* *zip*

Phone number: ☐☐☐ - ☐☐☐ - ☐☐☐☐
area code

Relationship to Deceased: _____

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