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 Touro College of Dental Medicine, for medical study and research.**

OR

☐ **I hereby direct that the body of ____ recently deceased, be delivered to Touro College of Dental Medicine, 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: Touro College of Dental Medicine 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 school of medicine's crypt in Ferncliff Cemetery, in Hartsdale, NY.

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

Address ____

City/State ____

Signature ____ **Dated** ____________________

Witness ________________________ **(Print)**	**Witness** ________________________ **(Print)**
Address ________________________	________________________
City/State ________________________	________________________
Signature ________________________	________________________
Dated ________________________	________________________

TOURO COLLEGE OF DENTAL MEDICINE
AT NEW YORK MEDICAL COLLEGE

Department of Cell Biology and Anatomy

Body Bequeathal Program - Confidential Statistical Information

<table>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Present
Address:</td></tr>
<tr><td>Telephone Number:</td><td colspan="2">Social Security No.:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2">Place of Birth:</td></tr>
<tr><td>Medicaid Number:</td><td>Sex: Female / Male</td><td>Race:</td></tr>
<tr><td>Are You a US Citizen? YES / NO
If No, Please Specify:</td><td colspan="2">Are You of Hispanic Origin? YES / NO
If Yes, Country of Origin:</td></tr>
<tr><td>Father's Name:</td><td colspan="2">Mother's Name: ______________________
(Include Maiden Name)</td></tr>
<tr><td colspan="3">Your Occupation (Prior to Retirement): ______________________
Name of Business: ______________________
Type of Business: Location:</td></tr>
<tr><td colspan="2">War Veteran: NO / YES - War Served:
Dates Served: From: To:</td><td>Last School Grade
Completed</td></tr>
<tr><td>Marital Status:</td><td colspan="2">Spouse's Name: ______________________
(For Wife, Include Maiden Name)</td></tr>
<tr><td colspan="3">Spouse's Address & Telephone Number (If Different From Yours):</td></tr>
<tr><td colspan="3">Name of Closest Relative:______________________
Address:______________________
Telephone Number:______________________
Relationship to You:______________________</td></tr>
<tr><td colspan="3">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:</td></tr>
<tr><td colspan="3">______________________________________
Signature Date</td></tr>
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