

Thank you for your interest in Science Care, the first accredited whole body donation program for medical research, training and professional education.

One of the great dreams of humankind is to create a brighter future for each generation that follows. As the nation's leading whole body donation program, we provide the chance to make a contribution that benefits others.

Science Care's program contributes to new breakthroughs and developments in medicine, including advanced physician training, development of new medical devices and safer, more effective treatments for patients. Each development provides hope for a healthier future and enhances the generous bequests of our donors.

As you plan for the future, we hope you will consider the following:

1. Ease of Registration

- ❖ To register, simply complete the enclosed forms and return in the postage-paid envelope. *Checklist included for registration help.*
- ❖ Your Science Care ID cards will be mailed in two weeks.
- ❖ Science Care pays **all costs** for donation: transportation from the place of passing to our medical facility, death certificate filing, and cremation.
- ❖ Donation available in **nearly every state** with the current exception of Minnesota and New Jersey.
- ❖ Return of the cremated remains (if requested) within 3-5 weeks.

2. Donation Criteria

- ❖ The vast majority of potential donors are **accepted**, including people with cancer, heart disease, MRSA, C-diff, lupus, ALS, arthritis, stroke, and diabetes. Organ transplant donors *are* eligible for Science Care donation.
- ❖ While we strive to accept every donation, final acceptance is contingent upon medical and suitability criteria at the time of passing, to honor the intent of donation and safely serve the needs of the medical community.
- ❖ Exclusions may include contagious diseases (i.e. hepatitis B & C, HIV/AIDS), extreme obesity or decomposition, certain past surgical procedures and bone and joint issues.

3. About Science Care

- ❖ Science Care is the first non transplant organization to have earned **accreditation** from the American Association of Tissue Banks (AATB) and is licensed by the New York Department of Health, which means we hold ourselves to the highest standards possible.
- ❖ We adhere to all federal and state legal requirements including the Uniform Anatomical Gift Act.
- ❖ All information provided is kept **confidential** with secured access.

Should you have any questions about Science Care and how you can contribute to the health and well-being of future generations, please don't hesitate to call our Family Services department at 800.417.3747 or visit our website, www.sciencecare.com.



Registration Instructions

Please read carefully before completing forms.

Step 1: Self Donation & Cremation Authorizations

(Required)

- Please read both forms carefully. If you have any questions, do not hesitate to contact Science Care, 800.417.3747.
- You and your witnesses must *sign and date on the same day*. Forms are invalid if dates do not match.
- Keep the yellow copy of both forms for your records.
- Witnesses can be legal next of kin (recommended), family, friends, or other persons. The forms do not need to be notarized.

Completed:

Yes No

Step 2: Personal Information Form

(Optional)

- Please make sure you complete the form in its entirety; it is necessary for death certificate processing.
- Your social security number is not required now, but will be needed at the time of passing from the next of kin.
- All information is kept confidential with secured access.

Completed:

Yes No

Step 3: Mail to Science Care

- Using the enclosed postage-paid envelope, mail the following completed documents to Science Care:
 - Self Donation Authorization, white copy
 - Self Cremation Authorization, white copy
 - Personal Information Form

Completed:

Yes No

Following Registration

- Science Care will mail personalized ID cards to your address once the completed information and authorization forms have been received.
- You will receive four (4) ID cards. Please carry one with you and distribute the others to your loved ones or those who will be responsible for your arrangements.
- Please inform your loved ones of your registration with Science Care. You or your family may call anytime with questions, 800.417.3747, or visit our website, www.sciencecare.com.



Self Donation Authorization

I, _____, being greater than 18 years of age, authorize the donation of my body to

Science Care as governed by the disclosures listed in this document and as indicated below:

My Address is:

Address	_____	Phone	_____
City	_____	State	_____
		Zip Code	_____

1. I understand this authorization to proceed with donation is not a contract for services with Science Care, but is an expression of my intention to proceed with the donation assessment and acceptance process. I understand that acceptance is contingent upon medical and suitability criteria at the time of death, and is not a guarantee by Science Care.
2. I understand that I may revoke or amend this gift prior to my death.
3. I understand my legal next of kin or my estate will not be charged for the costs related to this donation.
4. I confirm that this gift is being made voluntarily without any obligation of any kind on the part of Science Care.
5. I understand that this donated gift may be used for multiple educational, scientific and/or medical research purposes.
6. I understand that the donation of this gift may require embalming, the surgical removal of the arms, legs, head, spine and other tissues from my body, and such donated gifts will not include use for general public display.
7. I understand this gift may be used for the purposes stated above both domestically and internationally.
8. I understand this gift, as represented to me by Science Care, will be treated with respect and dignity within the confines of the stated use and will not be used for any other purpose than stated above.
9. I understand that consenting to this gift does not guarantee any outcomes or assure the release of information pertaining to any outcomes from educational or medical uses or research performed with this gift. I also understand that my estate or my legal next of kin will not be entitled to reward or compensation as a result of donating this gift or outcomes of its use.
10. I understand this donated gift will be transported to a Science Care facility.
11. I understand that an open viewing during funeral/memorial service will not be possible upon donation of this gift.
12. I understand blood specimens will be tested for certain communicable diseases including, but not limited to HIV (AIDS) and Hepatitis B & C and that Science Care is required to comply with all state laws regarding reporting of communicable diseases.
13. I authorize the release of all my medical information such as hospital records, physician records, and autopsy reports to Science Care to determine medical suitability of this donation.
14. I understand that all health protected information collected by Science Care as defined by the Health Insurance Portability and Accountability Act (HIPAA) will be coded to maintain anonymity and confidentiality. Science Care must adhere to all applicable confidentiality laws.
15. I understand that Science Care is a for-profit company that partners with both for-profit and non-profit entities for medical educational & research purposes.
16. I understand that Science Care operates in accordance with applicable Standards of the American Association of Tissue Banks (AATB) and the AATB's published ethical guidelines, as well as all state and federal laws.
17. I understand that it is my responsibility to notify my legal next of kin or personal representative of my decision to donate my body to Science Care and their right to provide written request for my cremated remains. I understand that Science Care can not be held liable for my failure to notify family or others of my decision.
18. I understand the return of cremated remains does not include tissues that have been recovered for medical research or educational purposes.
19. I understand that Science Care or its assignee may arrange for the final disposition of tissues utilized for medical research or educational purposes in any manner, subject to local, state, or federal law.
20. **I hereby verify my understanding of all listed disclosures with adequate time for consideration and all questions having been answered.**



It is important that you and your witnesses sign on the same day:

X

Donor Signature

The undersigned acknowledge that the donor either: (1) signed this document; or (2) requested another to sign it for him/her since he/she was unable to do so. If signed by another person, I certify that I signed it at the donor's request and in his/her presence and the presence of each other. The donor's acts in signing this document or directing another to sign for him/her appeared to me to be his/her free and voluntary act.

X

Witness Signature

Donor Printed Name

Witness Printed Name

Date Signed

Date Signed

X

Witness Signature

Witness Printed Name

Date Signed



Self Cremation Authorization

I, _____, hereby authorize *Science Care* to cremate the remains of my body as governed by the disclosures listed in this document. I authorize the cremation of my body following donation as indicated below:

My Address is:

Address _____ Phone _____
 City _____ State _____ Zip Code _____

1. I understand that cremation of my body is necessary and mandatory as part of the donation process and that under no circumstances will un-cremated remains be returned to my estate or next of kin.
2. I understand the return of cremated remains does not include tissues that have been recovered for medical research or educational purposes.
3. I understand that Science Care or its assignee may arrange for the final disposition of tissues utilized for medical research or educational purposes in any manner, subject to local, state, or federal law.
4. I understand that due to the nature of the cremation process any material, including dental gold, will either be destroyed or not be recoverable.
5. I understand that my next of kin may remove or request the removal of any personal effects accompanying my body at the time of this gift. In the absence thereof, I understand that such personal effects will be destroyed if uncollected prior to donation or if no next of kin could be located.
6. I understand that mechanical devices implanted in my body prior to death may create a hazardous condition during the cremation procedures and must be identified and possibly removed prior to the commencement of cremation.
7. I agree to release from liability the Crematory, its affiliates, and their agents and employees, against loss from any and all claims, demands, or damages which may be made by or declared against it or them (except for willful or intentional misconduct), or by reason of my failure to timely disclose the existence of such an implanted device(s) or personal effects.
8. I understand that cremated remains are bone fragments that will be placed in a rigid container designed for short term use and for shipment.
9. I understand that every effort will be made to avoid inadvertent or incidental commingling of minute particles of cremated remains from the residue of previous cremations. However, inadvertent or incidental commingling is a possibility, and I accept this fact.
10. ***I hereby verify my understanding of all listed disclosures with adequate time for consideration and all questions having been answered.***

Cremated remains will be available to next of kin. If you wish to designate final disposition **please check one option** below:

A _____ Cremation **with** the return of cremated remains:
Ship To Name: _____

OR _____ Ship To Address: _____

B _____ Cremation **without** the return of cremated remains:
I designate *Science Care* or its assignee to dispose of the remains subject to local, state, or federal law.

➔ It is important that you and your witness sign on the same day:

X _____ **Donor Signature** _____ **Donor Printed Name** _____ **Date Signed**

The undersigned acknowledge that the donor either: (1) signed this document; or (2) requested another to sign it for him/her since he/she was unable to do so. If signed by another person, I certify that I signed it at the donor's request and in his/her presence and the presence of each other. The donor's acts in signing this document or directing another to sign for him/her appeared to me to be his/her free and voluntary act.

X _____ **Witness Signature** _____ **Witness Printed Name** _____ **Date Signed**



Personal Information Form

All information provided is kept confidential with secured access.

Full Name <i>First Middle Last</i>			Date of Birth <i>MM DD YYYY</i>		
Sex	Social Security Number			Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician Name <i>First Last Degree</i>			Physician Phone Number		
Birthplace <i>City County State or Country</i>				Citizen of What Country	
Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married but Separated (AZ only)					
Spouse <i>First Middle Last (Maiden name for wife)</i>					
Email Address of Spouse			Email Address of other NOK		
Primary Occupation <i>List only one</i>		How Long in Occupation		Type of Industry <i>List only one</i>	
Usual Residence <i>State County City ZIP Code</i>				Do You Live on a Reservation? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Reservation: _____ <input type="checkbox"/> No	
How Long in State		How long in County		Previous State of Residence	
Race					
Hispanic Origin <input type="checkbox"/> Not Spanish, Hispanic, or Latino <input type="checkbox"/> Mexican, Mexican-American or Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other: <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean		<input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify): _____ <input type="checkbox"/> Other Pacific Islander (Specify): _____ <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Am Indian or AK Native	
Education <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9-12 th no diploma <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Some College No Degree <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree					
Father's Full Name <i>First Middle Last</i>				State of Birth	
Mother's Full Maiden Name <i>First Middle Last (Maiden Name)</i>				State of Birth	
By signing below I attest that this information is complete and accurate:					
<i>Signature</i>		<i>Printed Name</i>		<i>Date</i>	