

**Bequeathal Form**

**FAXES/EMAILS ARE NOT ACCEPTED**

I, of sound mind and beyond 18 years of age, wish to donate my body upon death, to the **Robert Wood Johnson Medical School Anatomical Association** for anatomical study, research, and the advancement of medical science. This arrangement is valid if my death occurs within the State of New Jersey.

I realize acceptance of this donation is contingent upon the condition of my remains and that the **Anatomical Association** reserves the right to refuse my donation. Therefore, it is agreed, if the **Anatomical Association** rejects my donation, the **full responsibility** for my remains will be assumed by the authorized person chosen by me and listed below, or by my estate.

The **Anatomical Association** may, at its discretion, transfer my body to an approved teaching institution, and may retain my donation for approximately three years. The **Anatomical Association** will cremate my remains upon completion of the studies. At that time, the authorized person and or secondary contact listed on the general information form, will be notified and offered a final disposition choice: 1) to receive the cremains, or, 2) allow the **Anatomical Association** to dispose of the cremains.

**PRINT Donor Information:**

Donor Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Donor's Signature \_\_\_\_\_ Date \_\_\_\_\_

1<sup>st</sup> Witness to donor's signature \_\_\_\_\_ Date \_\_\_\_\_

2<sup>nd</sup> Witness to donor's signature \_\_\_\_\_ Date \_\_\_\_\_

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**PRINT Authorized Person Information:**

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Authorized Person's Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_