Authorized Representative's Consent for Anatomical Donation to the Hackensack Meridian School of Medicine

To be completed by authorized representative of the prospective donor

Hackensack Meridian School of Medicine
Anatomical Donation Program
123 Metro Boulevard, Nutley, NJ 07110
Phone: 551-497-1375
Email: adp@hmsom.edu | Website: HMSOM.edu/adp

1. **Permission and Authorization**. I am authorized to make an anatomical gift of the donor's whole body both during and after the life of the donor. My relationship to the donor is set forth below. I am of sound mind and at least 18 years of age.

   By signing this Authorized Representative's Consent for Anatomical Donation, I hereby authorize and direct that immediately upon the donor's death, their whole body, shall be donated to the Anatomical Donation Program of the Hackensack Meridian School of Medicine, a New Jersey Nonprofit Corporation, located at 123 Metro Blvd., Nutley, NJ 07110 ("HMSOM Anatomical Donation Program") for the purposes of medical research or education.

2. **Donor Registry**. This consent to donate the donor's body is to be recorded on the HMSOM Donor Registry.

3. **HMSOM Anatomical Donation Program Documentation**. I have read the HMSOM Anatomical Donation Program Documentation at HMSOM.edu/adp ("Program Documentation"). A copy of the Program Documentation has also been provided to me. As the donor's authorized representative, I agree to abide by all of the requirements, policies and procedures set forth therein and further give permission for the donor's body to be utilized in accordance with the Program Documentation.

   a. *Embalming*. I authorize and give permission for the embalming of the donor's donated body.

   b. I understand and accept that medical education or research studies generally take between one (1) and three (3) years, and some donations or portions of donations may be kept for longer periods of time for those purposes.

4. **Notice**. If possible, prior to the donor's death, but not later than 24 hours following the donor's death, I will notify the HMSOM Anatomical Donation Program at 551-497-1375 or adp@hmsom.edu of the donor's anticipated death or actual death.

5. **Transfer of Donor's Body**. If applicable, I authorize the HMSOM Anatomical Donation Program, to transfer the donor's body to another institution authorized to receive anatomical donations, if appropriate, at the discretion of HMSOM.

6. **Transportation of Donor's Body**. I understand that the State of New Jersey is the designated donation area under the HMSOM Anatomical Donation Program. If the donor's death occurs in New Jersey, the HMSOM Anatomical Donation Program is hereby authorized to transport the donor's body in accordance with their policies and procedures. Within New Jersey, there will be no cost to the donor's authorized representative/family members related to transportation expenses of their body. Should donor's death occur outside of New Jersey, I authorize and direct that in accordance with the polices of the anatomical donation Program of HMSOM:

   Check ONE of the following two statements:

   ☐ (i) The donor's body will be donated to the medical school with an anatomical donation program located close to the location of the donor's death, and the authorized representative/family members are authorized to pay full transportation costs.

   ☐ (ii) The donor's body will be transported to the HMSOM and the donor's authorized representative/family members are authorized to pay the full transportation costs.

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7. **Return of Donor's Ashes**. I understand that there are certain circumstances under which anatomical donations may not be accepted as described in the Program Documentation. I acknowledge that in case the donor's body is not accepted by the HMSOM Anatomical Donation Program, it is the responsibility of the donor's authorized representative to make alternative arrangements for the disposition of the donor's body, including payment of the costs. If the donor's body is accepted to the HMSOM Anatomical Donation Program, I authorize and direct that:

   Check ONE of the following two statements:

   ☐ (i) The donor's ashes will be returned to person listed below who will assume responsibility for disposition.

   Name of Donor: ______________________________

   Person who will assume responsibility for disposition:

   Name of Recipient: ______________________________

   Address: ____________________ City: ____________ State: ______ Zip: ______

   Phone: ____________________ E-mail address: ____________________

   Relationship to Donor: ____________________

   ☐ (ii) The donor's ashes will be scattered in accordance with standard protocols.

Certification and Signature:

I certify that I have read and understand the terms and conditions of this Authorized Representative's Consent for Anatomical Donation, together with the HMSOM Anatomical Donation Program Documentation. I agree to all of the terms and conditions of the HMSOM Anatomical Donation Program and have voluntarily signed this form as the authorized representative of the donor and of my own free with no inducement to do so, financial or otherwise.

Printed Name of Authorized Representative: ______________________________

Address: ____________________ City: ____________ State: ______ Zip: ______

Phone: ____________________ Name of Donor: ____________________

Authorized Representative's Relationship to Donor: ______________________________

Signature of Authorized Representative: ____________________ Date: ____________

In the event I am unable to sign this Authorized Representative's Consent for Anatomical Donation form, I hereby direct another individual to sign on my behalf in the presence of two (2) witnesses, one (1) of whom shall be disinterested.

Printed Name of Individual Signing on behalf of Authorized Representative: ______________________________

Address: ____________________ City: ____________ State: ______ Zip: ______

E-mail Address: ____________________ Relationship to Donor: ____________________

Signature of Individual Signing on behalf of Authorized Representative: ______________________________

Two Witnesses (only necessary if donor is unable to sign and directing another individual to sign on their behalf)

Printed Name of Witness #1: ______________________________

Address: ____________________ City: ____________ State: ______ Zip: ______

E-mail Address: ____________________

Signature of Witness #1: ____________________ Date: ____________

Printed Name of Witness #2: ______________________________

Relationship to Donor (must be disinterested): ______________________________

Address: ____________________ City: ____________ State: ______ Zip: ______

E-mail Address: ____________________

Signature of Witness #2: ____________________ Date: ____________