The Albany Medical College deeply appreciates your desire to bequeath your body for the purpose of medical education and/or research. In order for this matter to be handled in an orderly fashion, the following suggestions are offered:

Enclosed are three (3) copies of a Declaration of Consent (DOC) form, of which the terms are self-explanatory and a Statistical Information Sheet. Read these documents carefully and then complete the forms. Please return only ONE (1) copy of the DOC, along with the Statistical Information Sheet to:

Albany Medical College
Anatomical Gift Program MC-135
47 New Scotland Avenue
Albany, New York 12208

The second copy should be kept by the person who will be contacting Albany Medical College at the time of the donor’s death, perhaps a next-of-kin, physician, attorney, clergyman, etc. The third copy should be kept by the donor for his/her records. We strongly suggest that donors discuss their wishes with family and friends so that everyone is aware of the Anatomical Gift Program’s policies and procedures.

In the event of your death, a member of your family or other appropriate individual should notify the Anatomical Gift Program at (518) 262-5379 for instructions. The College will need pertinent information about the donor, such as name, cause of death and age. We will also need the name, address and telephone number of the next-of-kin or person designated as power of attorney.

Upon notification of a donation, Albany Medical College will arrange for the removal and transportation of the body to the College. Should death occur at a distance, which makes timely delivery to the Albany Medical College impractical or excessively expensive, or should you move from the Capital District, we would be happy to provide the name and address of the nearest medical school with an anatomical gift program.

After receipt of your completed Declaration of Consent, a donor card will be issued (processing takes approximately 2 weeks). If you have any questions, please feel free to write or call the Anatomical Gift Program at the address and/or telephone number listed above.

Again, thank you for your very generous spirit in this matter and please be assured that you are making a noteworthy contribution to the education of young physicians.

Leon J. Martino, Ph.D.  
Director

Julie Chang  
Program Coordinator
ALBANY MEDICAL COLLEGE ANATOMICAL GIFT PROGRAM
DECLARATION OF CONSENT

As authorized by the provisions of the Uniform Anatomical Gift Act of the Public Health Law of the State of New York, I direct that, immediately after my death, Albany Medical College, be so notified and that within 24 hours following my death, my body be made available to them for the purpose of medical education and/or research.

Anatomical Gift Program, (518) 262-5379, fax (518) 262-5136

- It is understood that the Albany Medical College will arrange with contracted funeral homes to have my remains transferred to the Albany Medical College within 24 hours of death. The Albany Medical College will pay the expenses of delivery of my body to the Albany Medical College within a 130 mile radius of the Albany Medical College (death certificates, obituaries, register books, prayer cards, a memorial service other than AMC’s, etc. are not included). If death shall occur outside this radius, Albany Medical College will make arrangements for the transportation of my body to the Albany Medical College. In this case, however, the Albany Medical College will reimburse an undertaker for transportation expenses only, not to exceed the amount of $300.00; any additional expenses will be borne by my estate, and I have so directed the executor of my estate. If preferred, a specific funeral home may be used however they must agree to the Albany Medical College’s payment structure and all additional costs are borne by my estate. If one is requested, the family or heirs should notify us at the time of death.

- It is understood that determination of acceptability is determined at the time of death and that the Albany Medical College reserves the right to decline the donation under conditions where there is family dissent or in which the remains are deemed unsuitable for educational or research purposes. Examples of such conditions include extreme decomposition, autopsy, infectious diseases or obesity. In the event that Albany Medical College declines my donation, alternate arrangements for the disposition of my body should be considered. If my donation is declined, my heirs or others legally empowered to act in such matters, will be responsible for the deposition of my remains. Albany Medical College encourages organ donation, and will not decline your donation following organ donation.

- It is understood that following my donation the Albany Medical College may, if desired, perform infectious disease blood tests (hepatitis B, hepatitis, C and HIV) or request copies of my recent medical records for such purposes as to determine the suitability of applicable studies. The Anatomical Gift Program is not empowered to perform an autopsy and does not release findings or medical records.

- It is understood that at times of need, my remains may be transferred to another medical school for the purposes of medical education and/or research, unless I have notified the Albany Medical College otherwise, in writing.

I have a read and understand the statements contained within this Declaration of Consent

Signature _______________________________
Following their use for educational and/or research purposes (approximately 12 to 24 months), all bodies are individually cremated. One of the following interment options for the final disposition of the cremains **MUST** be checked:

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According to the law of the State of New York, donors of bodies must be of sound mind and be at least eighteen years of age. This document must be signed by the donor in the presence of two witnesses who are at least 18 years of age. These forms need not be notarized.

**Please print or type all information clearly:**

- **Name (Mr.-Mrs.-Miss-Ms.)**______________________________________________________________________
- **Address**______________________________________________________________________________________
  - street                                       city                                state                                zip code
- **Telephone(____)_________________Date of Birth_________Social Security #_______________________________
- **Donor's Signature**_____________________________________________  **Date**______________________
- **Witness Signature**_____________________________________________  **Date**______________________
- **Witness Signature**_____________________________________________  **Date**______________________
Statistical Information Sheet Concerning Donor (Yourself) is Required for the Proper Completion of the Death Certificate. (Please print or type)

Name: First____________________ M.______ Last______________________  DOB:____________________

City & State of Birth_________________________________ SS#_________________________________

Current Address & County____________________________________________________________________

Phone # _____________________ Race________________________ Height ______________  Weight ______________

US Armed Force? No _____ Yes _______ War or Service Dates________________________

Usual Occupation (do not enter retired) __________________________________________ City/St.

Kind of Business or Industry__________________________________________________ Homemaker Y ______ N ______

Education Level <8th gr.________ 9th-12th gr. W/ Diploma _____ 9th-12th W/GED _______

College: Associate’s Degree ______ Bachelor’s Degree ______ Doctorate/Professional Degree _______

Fathers Full Name ______________________ Fathers Place of Birth City & St.____________________

Mothers First& Maiden Name ______________________ Place of Birth City & St.____________________

Marital Status: _____________ Spouse’s First & Maiden Name ______________________

Spouse’s Address & Phone # (if different) __________________________________________

Physician: Name ____________________________________________

Addresss ____________________________________________

Telephone ____________________________________________

Medical History and other Pertinent Information is vital to determine the suitability of applicable studies. Please include chronic conditions and any major procedures or surgeries. This Information will NOT hinder your donation.
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