

COMMONWEALTH OF VIRGINIA  
INSTRUMENT OF ANATOMICAL GIFT

DECLARATION OF INTENT

I \_\_\_\_\_, desire to donate my body for scientific study, teaching, research, or other purposes as needed by the State Anatomical Program of Virginia Department of Health. I understand that donation must take place prior to embalming or autopsy and that if my body is not anatomically acceptable because of certain conditions or injury that my estate is responsible for the final disposition of my remains.

\_\_\_\_\_  
(SIGNATURE) Date: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

WITNESS ATTESTATION

Print Name \_\_\_\_\_ Relationship to Donor \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
\_\_\_\_\_  
Signature \_\_\_\_\_

PERSONAL INFORMATION CONCERNING DONOR  
(For Vital Records completion)

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_  
Sex \_\_\_\_\_ Race \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Mother's Full Maiden Name \_\_\_\_\_ Father's Full Name \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Highest level of education \_\_\_\_\_ College \_\_\_\_\_ Service in the armed forces: YES or NO (Circle one)  
(K-12) (# of years)  
Usual or Last Occupation \_\_\_\_\_ Kind of Business or Industry \_\_\_\_\_  
Closest Next of Kin Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address \_\_\_\_\_

Procedure at the time of death: Notify the Anatomical Program immediately at the time of death.  
(804) 786-2479

**PLEASE PRINT OUT AND COMPLETE THIS FORM.**

**PLEASE RETURN THIS FORM TO:**

Virginia State Anatomical Program  
400 East Jackson Street  
Richmond, Va. 23219

**We suggest that copies are made of the completed form and kept for your personal records**