

**FORM 1: DEDICATION FORM FOR DONATION TO THE VIRGINIA STATE ANATOMICAL PROGRAM (VSAP) FORM**

By completing and submitting this Dedication Form I am expressing my desire to donate my body for scientific study, teaching, research, or other purposes as needed to the Virginia State Anatomical Program (VSAP) of the Virginia Department of Health. I have read and considered all of the information contained in the document titled “Donating your body to the Virginia State Anatomical Program” and the Acknowledgments included on this Form.

**BODY DONOR INFORMATION**

**(For Vital Records completion of Death Certificate)**

**(Please print legibly)**

Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **last) (First) (Middle/Maiden)**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place (State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Highest Level of Education: \_\_\_\_\_\_\_\_\_\_ College: \_\_\_\_\_\_\_\_ Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Veteran (Y/N) \_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Full Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual or Last Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type/Kind of Business or Industry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*This person will serve as the spokesperson for your estate and will be contacted by VSAP following your death regarding the authorization to accept your body to our program.

**Acknowledgements**

1. I understand that VSAP may, at its sole discretion, due to certain medical conditions, condition of my body or delay in the report of my death, reject the donation of my body at the time of death. I understand that if this occurs, the designated survivor/responsible party will be responsible for the final disposition of my remains.
2. I understand the VSAP may provide a donated body and/or part of the body to educational institutions, research, institutions or non-profit entities in a manner to be determined exclusively by the Program, pursuant to policies and procedures that are in effect at the time of a donor’s death or as they may be revised thereafter.
3. I understand that organs, tissues, or parts of the body may be removed or separated and sent to different entities and these parts may be disposed of at different times and at different locations.
4. I understand that I may revoke a donation at any time prior to death and that no other person can revoke my donation.
5. I understand that VSAP may keep my remains for an indefinite time if so designated at the time of death or the next of kin/responsible party may request in writing, by submitting the “Request for the Return of Cremated Remains” form that my cremated remains be returned to them following the study. At minimum the cremated remains of the head and torso will be returned as requested. VSAP will use its best efforts to ensure my remains are returned if requested.
6. I understand that following the study my remains will be cremated in accordance with the laws of the Commonwealth of Virginia.
7. I give VSAP my permission to release my medical information to the faculty and staff of any recipient program when needed in order to facilitate the preparation and study of my remains for educational and/or research purposes.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure at the time of death: Notify VSAP immediately at the time of death at 804-786-2479**

**PLEASE PRINT OUT AND COMPLETE THIS FORM (Keep one copy for your records)**

**PLEASE RETURN FORM TO:**

**Virginia State Anatomical Program**

**400 E. Jackson St.**

**Richmond, VA. 23219**