

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

**(Acceptance for Donation is Not Guaranteed)**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 that 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Appointed Agent\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # of Appointed Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Appointed Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*This person will serve as the person of contact by VSAP following your death regarding the authorization to accept your body to our program.

**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**

**\*\*\*\* You should contact VSAP offices 2 years after submitting the forms to update any information\*\*\*\*\***

**Appointment of Agent to Carry Out Specified Duties**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby appoint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to

 (List Full Name) (List Full Name)

arrange and direct those actions initialed below in the event of my death as allowed by the Code of Virginia 54.1-2825. This individual will have priority over all persons otherwise entitled to arrange and direct those actions I have initialed below following my death. This agency by appointment is limited to only those specific activities listed below.

**Initials Activities**

\_\_\_\_\_\_ Authorize the Donation of my body (if anatomically and medically suitable) to the Virginia State Anatomical Program as stated with my submission of a Declaration of Intent.

\_\_\_\_\_\_ Provide information pertaining to the physical, health, and medical condition of my body after death to the Virginia State Anatomical Program to determine the suitability of my body for acceptance.

\_\_\_\_\_\_ Arrange for the disposition of my cremated remains upon the completion of my donation to the Virginia State Anatomical Program

\_\_\_\_\_\_ Arrange for burial or disposition of my remains, including cremation upon my death in the event I have not been deemed acceptable for donation by the Virginia State Anatomical Program.

**To be completed by designated agent and donor:**

I agree to accept the responsibility of those actions initialed above by the individual whom has appointed me to arrange and direct them.

(Designee) Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name

(Donor) Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name

Commonwealth of Virginia

City/County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 The foregoing was acknowledged and sworn to before me, the undersigned Notary Public,

by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ & \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this \_\_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_

 (Donor) (Designee)

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Notary Public