Thank you for your request for information concerning our Anatomical Gift Program. Donations to the School of Medicine are used for purposes of medical education. Enclosed are the following forms:

1. **A Bequeathal form.** This form must be signed by the Donor in the presence of a minimum of one witness who is at least 18 years of age. Please make three copies, one should be returned to the Coordinators at the Office of the Anatomical Gift Program; the remaining forms should be distributed as indicated on the form, or to any person the Donor wishes to have knowledge of his/her decision.

2. **An Information form #1.** The Donor fills out the first 17 questions and returns the form to the Coordinators of the Anatomical Gift Program.

3. **An Information form #2.** This form is to be completed and signed by the next of kin and/or the Executor after the Donor’s death; completing questions 18 through 30 and sent to the Coordinators of the Anatomical Gift Program.

4. **A Medical School Affidavit.** This form is to be completed and signed by the next of kin and/or the Executor after the Donor’s death, the signature is notarized, and the form given to our transporter or sent to the Coordinators of the Anatomical Gift Program.

5. **An Application for Cremation Permit.** This form is to be completed by the next of kin and/or Executor after the Donor’s death, the signature notarized, and the form given to our transporter or sent to the Coordinators of the Anatomical Gift Program.

6. **Remains to Family form.** This form is to be completed and signed by the next of kin and/or Executor after the Donor’s death and returned to the Coordinators of the Anatomical Gift Program.

**At the time of death the next of kin should contact The Anatomical Gift Program at (212) 241-7276.**

Our office hours are Monday to Friday from 9 a.m. to 5 p.m. If you need to contact us during evening hours, weekends, and holidays, please PAGE us at (917) 641-0063 or (917) 641-0094 and leave a return number. We will return the page as soon as possible to gather the Donor information and make the necessary arrangements with our Funeral Director to pick up the Donor.

Once we have transported the remains and obtained the cremation permit and medical school affidavit, the family has no further responsibilities. The Icahn School of Medicine at Mount Sinai will assume all expenses, except for copies of the death certificate. The cost of the death certificate is $15.00 per copy along with a New York City Department of Health processing fee of $80.00.

**PLEASE NOTE:** We will not accept a body that has been autopsied/embalmed, and we reserve the right not to accept a body in excess of 250 lbs. We will also not accept the remains of someone who has had an active communicable disease at death. The deceased must have next of kin or an executor of his/her will to qualify for the program.

Sincerely,

Tarin Rivera
Torrence Wilson
Anatomical Gift Program Coordinators
Icahn School of Medicine at Mount Sinai
Anatomical Gift Program  
Icahn School of Medicine at Mount Sinai

Bequeathal Form

Being of sound mind and over the age of 18, I hereby make this anatomical gift of my body to the Icahn School of Medicine at Mount Sinai of the City of New York, to take effect upon my death, and I direct that after my death my body be delivered to the Icahn School of Medicine at Fifth Avenue and 100th Street, New York City. My body may be used by the Icahn School of Medicine for medical education, research, and any other purpose authorized by law. I understand that the Icahn School of Medicine will pay for transportation costs within the 5-borough radius of New York City. The remains of my body will be cremated by the agent of the Icahn School of Medicine.

If the Icahn School of Medicine is unable to accept by body (either because an autopsy has been performed or because my next of kin does not agree to pay the transportation costs if I die outside the 5 borough radius, or for any other reason), I hereby direct my next of kin to offer my remains to the nearest medical school to be used for the purpose stated above.

Date: _____________________________

Name of Donor and/or Deceased: (Print Clearly) ________________________________

Signature: ____________________________

Address: (Print Clearly) ____________________________

City, State, and Zip: (Print Clearly) ____________________________

Telephone and/or Cell phone Number: ____________________________

Social Security Number: ____________________________

Date of Birth: ____________________________

SIGNED BY THE DONOR IN THE PRESENCE OF THE FOLLOWING WHO SIGN AS WITNESS (ES):

Signature of Witness ____________________________ Signature of Witness ____________________________

Address ____________________________ Address ____________________________

☐ Donor Copy ☐ ISMMS Copy ☐ Next of Kin/Executor ☐ Doctor’s Copy ☐ Lawyer’s Copy
Information Form Page 1
(Complete the questions below and return this form to the Office of the Anatomical Gift Program)

1. Full Name of Donor:__________________________________________

2. Please list other name(s) by which the Donor is known:__________________________________________

3. Address:__________________________________________
City:________________________ State:__________ Zip Code:__________
Telephone and/or Cell phone:__________________________________________

4. Date of Birth: Month ______ Day ______ Year ______

5. Marital Status: □ Single □ Married □ Widowed □ Divorced

6. Birthplace (City/State, and/or Foreign Country):________________________

7. Full Name of Spouse:__________________________________________
(If wife, please give full maiden name)

8. Occupation During Working Period:__________________________________________

9. Level of Education Achieved:__________________________________________

10. Type of Business and/or Industry:__________________________________________

11. Social Security Number: (Please Print Clearly)__________________________________________

12. United States Veteran: □ Yes □ No

13. Full Name of Donor’s Father__________________________________________

14. Full Name of Donor’s Mother (Maiden)__________________________________________

15. Name of Next of Kin and/or Executor of the Will:__________________________________________

16. Please specify Relationship to the Donor:__________________________________________

17. Address for the Next of Kin and/or Executor:__________________________________________
City:________________________ State:__________ Zip Code:__________
Telephone and/or Cell phone__________________________________________
Email Address:__________________________________________
Information Form Page 2 - To be completed after the Death of the Donor.
(Complete the questions below and return this form to the Office of the Anatomical Gift Program)

18. Date of Death: Month ______ Day ______ Year ________

19. Place of Death (Institution or Hospital or Home): __________________________

Address: __________________________

City: __________________ State: ___________ Zip Code: ___________

Telephone: __________________________

20. Length of time in NYC prior to death: __________________________

21. Age at last birthday: __________________________

22. Citizen of what Country of demise: __________________________

23. Full Name of Informant: __________________________

24. Relationship to the Deceased: __________________________

25. Address: __________________________

City: __________________ State: ___________ Zip Code: ___________

Telephone and/or Cell phone: __________________________

26. Full Name of the Person Authorizing Donation: __________________________

27. Relationship to the Deceased (Next of Kin or Executor of the Will): __________________________

Address: __________________________

City: __________________ State: ___________ Zip Code: ___________

Telephone and/or Cell phone: __________________________

28. If the Donor’s spouse is deceased, please indicate the Date of Death: __________________________

29. Name of the Deceased Attending Physician: __________________________

Address: __________________________

City: __________________ State: ___________ Zip Code: ___________

Telephone: __________________________

30. Total Number of Death Certificates Requesting: __________________________
MEDICAL SCHOOL AFFIDAVIT

State of ________________________________

County of ________________________________

I, ________________________________ , residing at ________________________________, depose and say that I am the ________________________________ Next of Kin and/or the Executor of the Will for ________________________________ (Deceased Donor)

(Deceased Donor)

And that it is my desire to carry out the wish of said ________________________________ (Deceased Donor)

that (his/her) remains be delivered to the Department of Medical Education of the Icahn School of Medicine at Mount Sinai for use in teaching and for the promotion of Medical Science and Research.

In the event that the remains of the said ________________________________ (Deceased Donor),

are held at the City Mortuary, or similar authority, I hereby authorize the City Mortuary, or said similar authority, to release the remains to the designated agents of Icahn School of Medicine at Mount Sinai for delivery to the Department of Medical Education.

When the remains of the said ________________________________ (Deceased Donor) cease to be of value to the Icahn School of Medicine for said purpose, I authorize that the remains be cremated with the Laws of the State of New York at no cost to the family or estate of the Deceased, in agreement with the wishes of the Deceased.

__________________________________________
Signature of Next of Kin or Executor of the Will

Sworn to before me this ________________________________ day of ________________________________,
year__________________.

__________________________________________
Signature of Notary Public
VR 50 (REV 8/02) APPLICATION FOR CREMATION PERMIT

To the Office of Vital Records, Department of Health and Mental Hygiene, The City of New York

State ........................................
COUNTY OF ........................................... ss.:

........................................................................................................ being duly sworn deposes and says

that he/she resides at ........................................................................................................

and desires that a permit be issued by the Department of Health and Mental Hygiene of the City

of New York for the cremation of the body of: ........................................................................

who died at .............................................................................................................................. on ............................................................... (Date)

Deponent's assumption of authority to act is based upon the following:

Deponent further states that the deceased did express during life the desire to have
his/her remains cremated and his/her relationship to deceased is ...........................................................

Subscribed and sworn to before me this............. day of .................................................................

(Date) (Month) (Year)

...................................................................................................................

Signature

Notary Public-Commissioner of Deeds.................................................................................
REMAINS TO FAMILY FORM

Date:____________________

As the Executor and/or Next of Kin of ____________________________,

(Donor Name)

I request that the ashes be returned to:

Name:____________________

(Designated Recipient)

Address:____________________

City:____________________ State:_____________ Zip Code:___________

Telephone:____________________ Cell phone:____________________

Email:____________________

I understand that if the Anatomical Gift Program at the Icahn School of Medicine at Mount Sinai is unable to contact the Designated Recipient at the number and/or addresses above, within six months of notification, the remains will be interred at The Brick Church Cemetery, in Spring Valley, New York.

____________________
(Signature)

____________________
(Print Name)