Anatomical Gift Program (Whole Body Donation)
One Gustave L. Levy Place, Box 1007, Annenberg Suite 12-90
New York, NY 10029-6574
Telephone: 212-241-7276 Fax: 212-860-1174
Website: www.icahn.mssm.edu/bodydonation

Thank you for your request for information concerning our Anatomical Gift Program.

To Register as a Whole Body Donor complete the following 2 forms and submit the original forms to the Coordinators of the Anatomical Gift Program at the address above.

Bequeathal form. The Donor in the presence of one or more witnesses, who is at least 18 years of age, must sign this form. Please make multiple copies of the Bequeathal form and distribute as indicated on the bottom of the form, or to any person the Donor wishes to have knowledge of his/her decision.

The Donor must have a next of kin or an executor of is/her will to qualify for this program.

Information form #1. The Donor completes the questions 1-17.

Completing & submitting the 2 forms stated above concludes the registration process for the Anatomical Gift Program at the Icahn School of Medicine at Mount Sinai.

The following 4 forms need to be completed by the next of kin and/or the Executor of the will after the Donor expires.

Information form #2. The next of kin and/or the executor of the will completes questions 18-30.

Medical School Affidavit. The next of kin and/or the executor of the will completes the form and signs the form in the presence of a notary public.

An Application for Cremation Permit. This form also is to be completed by the next of kin and/or the executor of the will and signs the form in the presence of a notary public.

Remains to Family form. The next of kin and/or the executor of the will documents the Donor's wishes regarding the disposition of ashes.

Upon completion of the above 4 forms, the originals must be submitted to the Program Coordinators.

When death occurs, the next of kin or Executor of the will should immediately notify the Anatomical Gift Program Coordinators by calling (212) 241-7276. If it is outside of normal business hours, the Coordinators can be PAGED by dialing (917) 641-0063 or (917) 641-0094. After hearing a series of beeps, dial a return call back number. We will return the page as soon as possible to gather the Donor information and make the necessary arrangements with our Funeral Directors to transport the Donor.

The Icahn School of Medicine at Mount Sinai will assume all expenses, except for copies of the death certificate. The cost of each death certificate is $15.00, along with the one-time New York City Department of Health processing fee of $80.00.

PLEASE NOTE: We will not accept a body over 250 lbs or a body that has been autopsied/embalmed. We will also not accept the remains of someone who has had an active communicable disease at death.
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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. The Icahn School of Medicine, for medical education, research and any other purpose authorized by law, may use my body. I understand that the Icahn School of Medicine will pay for the cost of transportation of my body to the School, up to a distance of 120 miles. The agent of the Icahn School of Medicine will cremate the remains of my body.

If the Icahn School of Medicine is unable to accept by body (due to an autopsy or because my Next of Kin/Executor do not agree to pay transportation costs in excess of 120 miles, or if I die outside the United States, or for any other reason), I hereby direct my Next of Kin/Executor to offer my remains to the nearest medical school to be used for the purpose stated above.

Date: _________________________

Full Name of Donor: __________________________________________ (Please Print Clearly)

Address: _____________________________________________________

Apt # ______ City: __________________________ State: _______ Zip: ______________

Telephone Numbers (Home/Work/Cell): ____________________________

Social Security Number: __________________________ Date of Birth: ______________________

*SIGNED BY the Donor in the presence of one or more who sign as Witnesses:

* _____________________________________________________________
Signature of Donor

* _____________________________________________________________
Signature of Witness

* _____________________________________________________________
Signature of Witness

_________________________ ____________________________
Address of Witness Address of Witness

☐ Donor's Copy
☐ Copy for Next of Kin/Executor
☐ Doctor's Copy
☐ Attorney's Copy
1. Full Name of Donor: ____________________________________________
   (Please Print Clearly)
2. Please list other name(s) by which the Donor is known:
   ____________________________________________________________
3. Address: ____________________________________________________
   Apt #______ City: ______________ State: _______ Zip: __________
   Telephone Numbers (Home/Work/Cell): _____________________________
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/Partner: _________________________________
   (If wife, please give full maiden name)
8. Occupation During Working Period: _____________________________
9. Level of Education Achieved: _________________________________
10. Type of Career/Business or Industry: ___________________________
11. Social Security Number: (Please Print Clearly) ___________________
12. United States Veteran: ☐ Yes ☐ No ☐ N/A
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 your Relationship to the Donor: ___________________
17. Address for the Next of Kin and/or Executor: _____________________
   Apt #______ City: __________________________ State: _______ Zip: ______
   Contact Numbers (Home/Work/Cell): ______________________________
   _____________________________________________________________
   Email Address: _______________________________________________
Information Form (Page 2) - To be completed after the Death of the Donor.

18. Date of Death: Month _______ Day _______ Year _______

19. Place of Death (Institution/Hospital/Home): __________________________________________
   Address: ________________________________________________________________
   City: _________________________ State: _________ Zip: _______________________
   Telephone Number: ________________________________________________________

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


23. Full Name of Informant: ______________________________________________________

24. Relationship to the Deceased: ________________________________________________

25. Address: ________________________________________________________________
   Apt #: ______ City: _________________________ State: _________ Zip: __________
   Contact Numbers (Home/Work/Cell) ________________________________________

26. Full Name of the Person Authorizing Donation: ________________________________

27. Relationship to the Deceased (Next of Kin or Executor of the Will): ______________
   Address: ________________________________________________________________
   Apt #: ______ City: _________________________ State: _________ Zip: __________
   Contact Numbers (Home/Work/Cell): ________________________________________

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: _______________________
   Telephone: ________________________________

30. Total Number of Death Certificates Requesting: ______________________________
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 states  
that he/she resides at ______________________  
(Address)  
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 __________________________  
(Donor’s Name)  
who died at __________________________  
(Address)  
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)  

x  
Signature of Next of Kin or Executor of the Will  

x  
Signature of Notary Public
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 ____________________________

(relationship) ____________________________

(Deceased Donor-Please Print)

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
REMAINS TO FAMILY FORM

Date: ______________________

As the Next of Kin or Executor of ____________________________________________

(Donor’s Name/Please Print Clearly)

☐ I request that the ashes be returned to:

Name: ______________________

(Designated Recipient)

Address: ______________________

Apt #: ___________ City: ___________ State: ___________ Zip: ___________

Contact Numbers (Home/Work/Cell): ______________________

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.

☐ I request that the ashes be interred at The Brick Church Cemetery.

______________________________
(Signature)

______________________________
(Print Name Clearly)