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 its/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.

As of January 1st 2020 our Anatomical Gift Program has implemented new fees. The cost of each death certificate is $15.00, along with the one-time processing fee of $250.00 for a registered donor. The processing fee for an unregistered donor is $350.00. If you wish to have the cremains mailed to you or interred by the medical school in our cemetery plot the fee is $100.00. There are no fees charged should you decide to pick up the cremains from our office.

**PLEASE NOTE:** We will not accept a body that has been autopsied/embalmed. We will also not accept the remains of someone who has had an active communicable disease at the time of death. We also reserve the right to not accept a body if over 250lbs.

**Signature**

**Date**
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 (hereafter abbreviated ISMMS) in the City of New York, to take effect upon my death. I direct that after my death my body be delivered to the ISMMS at Fifth Avenue and 100th Street, New York City, for medical education, research and any other purpose authorized by law. I understand that the ISMMS will pay for the cost of transportation of my body to the School, up to a distance of 20 miles. The agent of the ISMMS will cremate the remains of my body.

If the Icahn School of Medicine at Mount Sinai is unable to accept my body (due to autopsy, because my Next of Kin/Executor do not agree to pay transportation costs in the excess of 20 miles, or if I die outside of 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: ____________________________

Name of Donor: (Please Print Clearly) ________________________________________

Name of Deceased Donor: (Please Print Clearly) ________________________________

Address: _________________________________________________________________

Apt#: __________ City: ______________ State: __________ Zip: ______________

Telephone and/or Cell Numbers: _____________________________________________

Social Security Number: __________________________ Date of Birth: ________________

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

OR

SIGNED BY NEXT of KIN/EXECUTOR for DECEASED DONOR in the presence of one or more who sign as Witnesses:

Signature of DONOR ______________________________ Signature NEXT of KIN/EXECUTOR FOR DECEASED DONOR ______________________________

Signature of Witness ______________________________ Signature of Witness ______________________________

Address of Witness ______________________________ Address of Witness ______________________________

Revised July 2021
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)

__________________________
Signature of Next of Kin or Executor of the Will

__________________________
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)