STATE UNIVERSITY OF NEW YORK AT BUFFALO - SCHOOL OF MEDICINE AND BIOMEDICAL SCIENCES
ANATOMICAL GIFT PROGRAM –128 Farber Hall, Buffalo, NY 14214-3000
Telephone: 716-829-2913 / FAX: 716-829-2915

DECLARATION OF CONSENT

I hereby direct that my body be delivered, after my death, to the State University of New York at Buffalo as an unrestricted gift for purposes of medical study and research; that such delivery be made as soon as possible, without embalming or autopsy.

☐ Miss / ☐ Ms. / ☐ Mrs. / ☐ Mr. / ☐ _____

PLEASE PRINT FULL NAME IN BOX ➔➔➔➔

Donor's signature MUST be witnessed by two (2) individuals, at least 18 years of age.

DONOR'S SIGNATURE*:* _____

Witness 1 signature:_____ ***Witness 2 signature***:_____

Witness 1 Address_____ *Witness 2 Address*:_____

_____ _____

DATE: _____

DONOR'S COMPLETE ADDRESS: _____

(Donor Mailing Address)_____

DONOR TELEPHONE NO.: _____

DONOR DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

(Power of Attorney may sign for Donor, but MUST attach photocopy of POA verifying authority to sign.)

DISPOSITION OF ASHES: (Please Initial Choice)

1._____ University Cemetery located on the Amherst campus of SUNY at Buffalo.

2._____ Roman Catholic burial in consecrated ground at Assumption Cemetery, Grand Island, NY.

3._____ Return ashes to **Next Of Kin/Cemetery/Funeral Director** for private interment.

Name:_____ Telephone No._____

Address:_____

_____

Relationship to Donor_____ **if Next of Kin, list 2nd option if necessary below

KEEP this copy for your records.

You may wish to make copies for your family, physician and/or attorney.

Date:

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(You may include additional information or a second choice of disposition of ashes on the reverse side.)

☐ Miss / ☐ Ms. / ☐ Mrs. / ☐ Mr. / ☐ _____

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Witness 1 Signature:_____ ***Witness 2 Signature***:_____

Witness 1 Address_____ *Witness 2 Address*:_____

_____ _____

DATE:_____

DONOR'S COMPLETE ADDRESS: _____

(Donor Mailing Address)_____

DONOR TELEPHONE NO.: _____

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2._____ Roman Catholic burial in consecrated ground at Assumption Cemetery in Grand Island, NY.

3._____ Return ashes to **Next Of Kin/Cemetery/Funeral Director** for private interment.

Name:_____ Telephone No._____

Address:_____

_____

Relationship to Donor_____

(You may wish to indicate a second choice or individual for disposition of ashes, or additional instructions on the reverse side.)

RETURN THIS ORIGINAL SIGNED FORM

(along with the EMERGENCY CONTACT INFORMATION form) **TO THE ABOVE ADDRESS list at the top of this page**

Date:

ANATOMICAL GIFT PROGRAM

128 Farber Hall, Buffalo, NY 14214-3000
Telephone: 716-829-2913
Fax: 716-829-2915

EMERGENCY CONTACT INFORMATION

Please complete the following Donor and Emergency Contact information so that we may include the proper information on your wallet card.

Donor Information:

DONOR'S NAME:_____

DONOR'S ADDRESS:_____

_____

Emergency Contact Information

NAME:_____

COMPLETE ADDRESS:_____

_____

RELATIONSHIP TO DONOR:_____

TELEPHONE NO.: _____

Please notify our office if this information changes so that we may send an updated wallet card with the proper imprinted information. Return with the Declaration of Consent form to:

Anatomical Gift Program
State University of New York at Buffalo
128 Farber Hall
Buffalo, NY 14214-3000

Date: