

**Yale University  
Yale School of Medicine  
Anatomical Donation**

**DOCUMENT OF GIFT**

*Please return this form to the address for the Human Anatomy Program designated at the bottom of this document. Please retain a copy for your records.*

Pursuant to Title 19a, Chapter 368i of the Connecticut General Statutes:

1. Being eighteen years of age or older and of sound mind, I, \_\_\_\_\_ (Donor), hereby give my human remains to be delivered after my death as an unrestricted anatomical gift to Yale University for the primary benefit of the Yale School of Medicine and its Human Anatomy Program.
2. I understand: (i) the Yale School of Medicine will only accept human remains in accordance with its policies, procedures, and applicable law, (ii) my accepted remains may be used in furtherance of Yale's educational and research mission, and (iii) as part of Yale's educational and research mission, my remains may be used for educational purposes by persons within and without the larger Yale community (e.g., without limitation, students, faculty, researchers, and persons associated with other educational and medical institutions, associations, and groups).
3. Please **CHOOSE ONE** by signing on the appropriate line below:

I request **final disposition** of my remains to be by cremation and burial at a Yale University plot in Evergreen Cemetery in New Haven, Connecticut. Signature: \_\_\_\_\_

**OR**

I request **final disposition** of my remains to be cremated and returned to my next of kin:

(Name)\_\_\_\_\_, (Address)\_\_\_\_\_.

I understand that the Human Anatomy Program will notify my next of kin by letter when my remains are ready for return. Remains not claimed within 6 months from notification will be interred in the Yale University plot in Evergreen Cemetery in New Haven, Connecticut. Signature: \_\_\_\_\_

**PLEASE NOTE:**

**Tissue may be retained for further study.**

**Time from donation to final disposition may range from 6 months to two years.**

4. I understand that signing this Document of Gift is voluntary. No treatment, payment, or enrollment or eligibility for any health plan or benefits is conditioned upon my signing this form. I understand that I may change or revoke this donation in accordance with Title 19a, Chapter 368i of the Connecticut General Statutes. By signing below, I confirm that I have read and understand this Document of Gift.

**DONOR**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

**WITNESS**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

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Address

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Relationship to Donor

### Documentation Required for Death Certificate

Please include the following information with the Document of Gift. This information is used to complete the death certificate. This information is kept as confidential records maintained by the Human Anatomy Lab.

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_

(Prior to retirement)

Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Veteran: \_\_\_\_\_

Spouse: (If wife, give maiden name): \_\_\_\_\_

Father's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

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#### Mail to:

**Yale School of Medicine, Department of Surgery Human Anatomy Program**

**300 Cedar Street, P.O. Box 208062, New Haven, CT 06520-8062**

**Please contact (203) 785-2813 with any questions.**

## Optional Information/Narrative

We have had requests from donors to write and share a narrative with students about themselves. We are pleased to now be able to fulfill this request. If desired, donors and their families are invited to provide such a narrative. At your discretion, this may include information about donor's childhood/upbringing, work/professional life, family, hobbies, health, and/or motivations for becoming a donor in our program.

You may also choose to have an anonymized version of your obituary made available to YSM for educational and research purposes. Please initial below if you wish to have your obituary shared for these purposes. For obituaries written by donor's next of kin, we will also contact them to obtain permission.

\_\_\_\_\_ (Initials)

***Please note: Only original writings authored by donors/their family members will be accepted. Please, no photographs or drawings. We cannot accept personal health information about individuals other than the donor. We may edit the narratives for length and to maintain anonymity and privacy of individuals. Please limit to two pages.***

I, \_\_\_\_\_ (Author), hereby confirm the following:

- I am the author of the narrative submitted with this authorization; this narrative is wholly and originally written by me.
- I give permission for the Yale School of Medicine (YSM) to edit my submission, as appropriate, to maintain the privacy of individuals named in the narrative. For example, names may be changed or redacted.
- I give permission for YSM to use such edited narrative for educational and research purposes, which includes but is not limited to posting and distributing the edited narrative as part of course materials via a secured YSM learning platform made accessible to students and faculty participating in Human Anatomy Courses.
- I understand that I am not required to sign this authorization in order to receive treatment or payment for care from any healthcare provider.
- I understand that information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.
- This authorization expires upon expiration of the copyright term applicable to my narrative. I understand that I may revoke this authorization at any time by notifying the Yale School of Medicine in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).
- No treatment, payment, or enrollment or eligibility for a health plan or benefits is conditioned upon my signing this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

**If submitting a narrative, please mail this page of the form with the narrative to:**

**Yale School of Medicine, Department of Surgery Human Anatomy Program  
300 Cedar Street, P.O. Box 208062, New Haven, CT 06520-8062  
Please contact (203) 785-2813 with any questions.**