Dear Potential Donor,

The Students, Faculty, and Staff of Lincoln Memorial University - DeBusk College of Osteopathic Medicine (LMU-DCOM) deeply appreciate your interest in our Anatomical Donation Program. The generosity of our donors is indispensable in providing our current and future health care providers with the best possible education and training. The legacy left by our donors will continue to touch the lives of every patient our health care providers treat.

If, after reading through the donor registration packet and researching our program, you choose to donate to the LMU-DCOM Anatomical Donation Program, please fill out the attached packet in full. It is important that all questions are answered, boxes checked, and the documents are signed and dated. If you have any questions during the process, please contact us.

Upon a tentative acceptance, you will be added to our donor registry and receive a tentative donor acceptance packet. This will include two (2) copies of your donor registration paperwork, a voluntary medical history questionnaire, two (2) donor ID cards, and instructions about what happens after a death occurs. Unfortunately, in the event that a donor may not be able to meet our program criteria at the time of death and LMU-DCOM is unable to accept the donation, we ask that you have an alternate plan of disposition.

Please feel free to contact us with any questions you may have.

LMU-DCOM Anatomical Donation Program
DCOMADP@LMUnet.edu
423-869-6745 or 865-585-7428
Instructions: This registration form is to be completed by an individual seeking to donate his/her body to Lincoln Memorial University's (“LMU” or “University”) Anatomical Donation Program or the Donor’s authorized representative. Please read this document in full and complete all information requested. For this form to be considered valid, the form must be signed and dated in the presence of two (2) witnesses as indicated below.

I, ____________________________, a resident of the State of ______________________, being of sound mind, over the age of 18, and of my own free will with the intent to help others, do hereby desire to bequeath the whole body remains of ____________________________ (“Donor”) to LMU-DCOM for the advancement of ____________________________.

I understand that the exact use of donation will be determined by LMU-DCOM’s Anatomical Donation Program based upon the needs of the program at the applicable time. I understand and hereby agree that this gift of whole body donation may be used for medical education, clinical training, and/or research by students, faculty, staff, and other health professionals. The University reserves the right to retain tissues and organs of interest for educational and research purposes. The University further reserves the right to use photography or other media to document studies for educational use or publication. I understand that this gift may be used in the development of educational materials that may have value, and I surrender all rights that may be claimed by the estate and heirs of the Donor. Furthermore, I understand that for those who elect to take part in LMU-DCOM’s long-term studies option, the Donor may be embalmed, and other preservation techniques may be applied as needed. If applicable this may include, but is not limited to, plastination.

SIGNATURE PAGE TO FOLLOW
REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
An anatomical donation may only be made by the intended Donor or an individual related to the decedent in the manner and in the order of priority listed below. Please check the box that best describes you:

I am the:

☐ 1. Donor. I am donating my own body.
☐ 2. Guardian or conservator (must be accompanied by court order)
☐ 3. Agent (documentation must be attached)
☐ 4. Spouse
☐ 5. Adult Child

☐ 6. Parent
☐ 7. Adult sibling
☐ 8. Adult grandchild
☐ 9. Grandparent
☐ 10. Other: Specify _________________________________

By initializing here, I hereby state that I have no knowledge of the identity of an individual who is ranked higher than me on the list above and that is available to make this donation. Additionally, I have no knowledge of any objection to this anatomical donation by the Whole Body Donor or any guardian or immediate relative of the Whole Body Donor.

MEMORIAL SERVICE RECOGNITION

The LMU-DCOM Anatomical Donation Program extends every effort to protect all personal and health information of our donors and keep their identity confidential. Following the services of our donors, we wish to honor their generosity by recognizing and memorializing their gift to medical education and research. This occurs annually during our memorial service when LMU-DCOM recognizes donors by adding their name to LMU-DCOM’s university memorial garden. LMU-DCOM does understand if you wish to not be recognized by name and we will add you as an anonymous donor. Please make your wishes known below.

☐ I would prefer to remain anonymous. I do NOT choose name recognition for the donation made to the LMU-DCOM Anatomical Donation Program.

☐ I am willing to be recognized for the donation made to the LMU-DCOM Anatomical Donation Program. Please print below how the name should appear on the memorial plaque:

Name: __________________________________________________________________

SIGNATURE PAGE TO FOLLOW
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Multi-year use of the whole body donation

LMU-DCOM strives to reunite donors with their families within three (3) years of a donation; however, there are times when our program has a need for extended study of a donor. If you would like to be considered for long-term or permanent study, please let us know by checking the appropriate box below. I understand that if my donation is chosen for long-term study, my next of kin or designated agent may not be able to receive the Donor’s cremated remains.

This option allows LMU-DCOM to use the whole body for a period longer than three (3) years.

☐ LMU-DCOM may use the donation for longer than three (3) years. I understand that the cremated remains may not be returned to the family or designated agent. I also understand that increased embalming and preservation procedures, including but not limited to plastination, may be used.

☐ I request that LMU-DCOM NOT use the full body donation for long-term study and return the cremated remains within three (3) years.

Cremation information

I understand that at the end of study, the Donor’s remains will be cremated. I authorize the cremation and select the disposition of the remains. It is the responsibility of the Donor, their next of kin, or designated agent to make sure that we have the correct up-to-date information.

Please indicate the disposition of the decedent’s cremated remains. (check only one):

☐ Bury the cremated remains in LMU-DCOM’s communal memorial cemetery plot.

☐ Return the Donor’s cremated remains to the individual(s) listed below:
  - If attempts to contact the designated representatives are unsuccessful at the end of the 90-day period following cremation, the cremains will be interred in LMU-DCOM’s communal memorial cemetery plot.

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<thead>
<tr>
<th>1st Contact for Delivery of Cremains</th>
<th>2nd Contact for Delivery of Cremains</th>
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<tbody>
<tr>
<td>Print Name</td>
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<td>Phone Number</td>
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<td>Street Address</td>
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<td>Relationship</td>
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SIGNATURE PAGE TO FOLLOW
REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
Having read this form in full and understanding its content, I hereby sign it in the presence of two (2) undersigned witnesses.

Printed Name of Donor or Donor’s Authorized Representative  Phone Number

Street Address  City  State  Zip Code

**WITNESS STATEMENTS**

**ATTENTION:** Witnesses must be at least 18 years of age. At least one (1) witness must be a disinterested witness, which means the witness must be someone other than the Donor’s spouse, child, parent, sibling, grandchild, grandparent, or guardian. Employees of Lincoln Memorial University who are associated with the Anatomical Donation Program may not serve as witnesses.

The Donor hereby signed this Anatomical Donor Registration form, and in the Donor’s presence and at the Donor’s request, we witnessed the Donor’s signature on this document:

**WITNESS 1**

Signature of Witness  Date

Printed Name of Witness  Phone Number

Street Address  City  State  Zip Code

**WITNESS 2 (DISINTERESTED)**

Signature of Witness  Date

Printed Name of Witness  Phone Number

Street Address  City  State  Zip Code
ANATOMICAL DONATION PROGRAM

FORM 2

STATISTICAL INFORMATION

Instructions: Please provide the following information for the individual whose body is being donated. This information is used to complete a Death Certificate. Please provide LMU-DCOM with updated information as it becomes available.

Complete legal name (first, middle, last, suffix):

Residence address:

Is residence within city limits? □ Yes □ No

Residence county:

Primary phone number: ( ) Alternate phone number: ( )

Social Security Number: - - - Email:

Date of birth: MM DD YYYY Place of birth (city and state, or foreign country):

Current marital status: □ Married □ Divorced □ Separated □ Single □ Widowed

If married, provide spouse’s full name (if wife, maiden name):

Father’s name (first, middle, last):

Mother’s name (first, middle, last, maiden):

Usual occupation before retirement:

Business or industry:

Served in the Armed Forces? □ Yes □ No

If yes, what Branch of Military?

Race:

□ White □ Japanese □ Samoan

□ Black or African American □ Korean □ Other Pacific Islander:

□ American Indian or Alaska Native □ Vietnamese Specify ______________

Name of tribe: ______________ □ Other Asian:

□ Asian Indian □ Other Asian: Specify ______________

□ Chinese □ Guamanian or Chamorro □ Unknown

□ Native Hawaiian □ Filipino

Hispanic Origin:

□ No, not Spanish/Hispanic/Latino □ Yes, Mexican, Mexican American, Chicano

□ Yes, Puerto Rican □ Yes, Cuban

□ Yes, other Spanish/Hispanic/Latino: □ Unknown

Specify ______________

Highest Level of Education:

□ 8th grade or less □ Associate degree (e.g., AA, AS)

□ 9th - 12th grade; no diploma □ Bachelor’s degree (e.g., BA, AB, BS)

□ High School graduate or GED completed □ Master’s degree (e.g., MA, MS, MEng, MEd, MSW, MBA)

□ Some college credit, but no degree □ Doctorate (PhD, EdD) or Professional degree (MD, DDS, JD)

□ Unknown

LMU Legal | Anatomical Donation Program Form 2 Statistical Information, eff. 6/22
ANATOMICAL DONATION PROGRAM
FORM 3
AUTHORIZATION TO RELEASE DONOR'S MEDICAL RECORDS AND HEALTH CARE INFORMATION

Instructions: Please read and review this document in full, complete all information requested, and initial as well as sign and date where indicated.

Donor Full Name: ____________________________________________

Donor Date of Birth: _________________________________________

Authorized Representative (if applicable): _________________________

I have elected to make a full body donation to Lincoln Memorial University - DeBusk College of Osteopathic Medicine's Anatomical Donation Program for educational and medical training purposes.

In order to increase the educational, research, and/or scientific value of this full body anatomical donation, I authorize and request any health care facility in which the donor was treated at any time within two (2) years prior, and any physician who at any time treated the donor within two (2) years prior to this inquiry to furnish to a representative of Lincoln Memorial University - DeBusk College of Osteopathic Medicine’s Anatomical Donation Program, any and all records, radiology reports, and/or lab reports concerning my case history, treatment, and examination. I release any such physician or health care facility from any and all responsibility or liability that may arise from this authorization. I also request that my personal representative, if applicable, cooperate in securing such information and documentation, if necessary. I have the authority to authorize the release of the donor’s medical records and have attached a copy of the documentation verifying that authority.

Please initial the following statements:

I acknowledge that the Donor’s medical records may contain information relating to testing, diagnosis, and/or treatment for sexually transmitted diseases; alcohol and/or drug abuse; and psychiatric services, and I agree that any information related to such testing, diagnosis, and/or treatment may be released.

I may revoke this authorization in writing at any time prior to my date of death.

A photocopy of this authorization may be used in lieu of the original.

I hereby authorize the use or disclosure of the Donor’s medical records as described above. I acknowledge and affirm that I am signing this authorization knowingly and voluntarily.

__________________________________________________________  _________________________
Signature of Individual Donor or Authorized Representative       Date

This authorization is in accordance with Tennessee Code Annotated § 63-2-101 and HIPAA requirements (45 CFR § 164.508 et seq).