LMU | DeBusk College *of* Osteopathic Medicine
LINCOLN MEMORIAL UNIVERSITY

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. Once completed, please mail the original paperwork to the address below. 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, and two (2) donor ID cards.. 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
6965 Cumberland Gap Parkway
Harrogate, TN 37752
DCOMADP@LMUnet.edu
423-869-6745 or 865-585-7428

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ANATOMICAL DONATION PROGRAM
FORM 1
REGISTRATION FORM

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
(Printed name of Donor or authorized representative)
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
(Printed name of Donor)
Medical education, training, and research. I understand I have the right to alter or revoke this donation at any time in writing. Furthermore, I understand that at the time of death, LMU has the right to decline the donation if the Donor does not meet the criteria of LMU-DCOM's Anatomical Donation Program and I have reviewed the basic criteria and other information provided by LMU-DCOM at:.

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, security, 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.

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 initialing 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 to 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.

Each year, LMU-DCOM holds a memorial service during which donors are recognized by name and their name is added to the university's memorial garden plaque. If you prefer not to be recognized by name, you will automatically be included as an anonymous donor, ensuring your gift it honored while your privacy is maintained.

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

If you are 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
REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

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. I understand that if my donation is chosen for long-term study, my next of kin or designated agent will be contacted to ask for consent.

Next of Kin (for purposes of communication during and after the donor's acceptance into the Program) Next of Kin could include the donor's Spouse; Adult Children; Adult Grand Children; Adult Siblings; Other Kin; Legal representative.
Please list 2 (If Possible)

(1st – Primary) Name: _____
(First) *(Last)*

Street: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

(2nd - Secondary) Name: _____
(First) *(Last)*

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

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.

1ST CONTACT FOR DELIVERY OF CREMAINS		2nd CONTACT FOR DELIVERY OF CREMAINS	
Print Name		**Print Name**	
Phone Number		**Phone Number**	
Street Address		**Street Address**	
City, State, and Zip Code		**City, State, and Zip Code**	
Relationship		**Relationship**	

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.

Signature Date

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

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

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:	☐ Other:
	☐ Asian Indian	Specify _____	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: Specify _____	☐ Unknown	
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	

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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).