PLEDGE FORM **I wish to be a donor!** Anatomical Gift Program

As authorized by the provisions of the Uniform Anatomical Gift Act of Public Health Law (section 4301) of the State of New York, I acknowledge that I am 18 years of age or older, able to make my own decisions and can personally sign this form.

This statement is to certify that I wish at the time of my death, shall I meet the program criteria for acceptance, to be delivered to the Anatomical Gift Program at SUNY Upstate Medical University to be used as an unrestricted gift to help further medical advancements and education.

In connection with this pledge, I have reviewed the Anatomical Gift Program brochure and understand its contents. I have had any questions fully answered and understand that I must meet the program requirements at the time of my death. I understand that a pledge to donate does not guarantee acceptance and it will be necessary for another choice of disposition should the program be unable to honor my wish.

I understand that this donation may be provided for use by an institution of higher education in New York State in which Gross Anatomy is an integral and required component of an accredited program to educate health professionals, provided the institution is licensed by the New York State Department of Health as a whole body user. I understand that a minimal portion of my donation may be retained for archival purposes.

I acknowledge and understand that upon completion of studies, the Anatomical Gift Program will provide cremation of my remains at a New York State licensed crematory and the cremated remains if requested will be returned to my next of kin or designee.

The Anatomical Gift Program reserves the right not to accept a donation if in the professional judgement of the program such donation is not suitable to accomplish the goals of the program.

If previously pledged: *(date/approximate date)* ☐☐ / ☐☐ / ☐☐☐☐ *month / day / year*

My name (print): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss _____

My signature: _____ Today's Date: ☐☐ / ☐☐ / ☐☐☐☐ *month / day / year*

My Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ *month / day / year* My Social Security#: XXX-XX- ☐☐☐☐ *last four numbers* My Height: ☐☐ *inches* My Weight: ☐☐☐ *pounds*

My mailing address *(print)*:

_____
postal address *city* *state* *zip*

My phone number: ☐☐☐ ☐☐☐ ☐☐☐☐ *area code*

I acknowledge and witnessed the person above signature on this form.

Witness Name *(print)*: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss _____

Witness signature: _____ Today's Date: ☐☐ / ☐☐ / ☐☐☐☐ *month / day / year*

Witness mailing address *(print)*:

_____
postal address *city* *state* *zip*

Witness phone number: ☐☐☐ ☐☐☐ ☐☐☐☐ *area code*

Return completed Pledge Form and Correspondence/Disposition of Cremated Remains Form to:

Anatomical Gift Program • Upstate Medical University, 750 E. Adams St. WH1133 • Syracuse, NY 13210
Phone: 315-464-4348 • Fax: 315.464.4350 • Email: *agp@upstate.edu*

Incomplete illegible forms are not acceptable.

UPSTATE MEDICAL UNIVERSITY

CORRESPONDENCE

Anatomical Gift Program

To whom should all correspondence be directed after death:

Donor Name (print): _____

Next-of-kin/Designee(print): _____ Relationship: _____

Address (print): _____
postal address *city* *state* *zip*

Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐
area code

DISPOSITION OF CREMATED REMAINS

☐ Return the cremated remains to the correspondent above.

☐ Return the cremated remains to (if different than above):

Name (print): _____ Relationship: _____

Address (print): _____
postal address *city* *state* *zip*

Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐
area code

☐ The cremated remains are not to be returned. The cremated remains will be held at the discretion of the program until they are interred in one of the Anatomical Gift Program burial plots.

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