



OHSU Body Donation Program

3181 Sam Jackson Park Road L341
Portland, Oregon 97239
(P): 503.494.8302 (F): 503.418.0588
(E): donation@ohsu.edu

Information on Donating Your Body to OHSU's Body Donation Program

About us: Founded in 1976, Oregon Health and Science University's Body Donation Program is the oldest non-profit whole body donation program in the state of Oregon. All donated bodies are handled in compliance with all federal and state laws, including the Oregon Anatomical Gift Act (revised 2007).

Mission: Donations to the Body Donation Program provide surgical simulation and research opportunities to practicing physicians, surgeons, and medical residents for the advancement of medicine. In addition, these donations help teach anatomy education to undergraduate and graduate level medical learners at Oregon Health and Science University and other similar teaching institutions in the Pacific Northwest.

Conditions: The Body Donation Program accepts donations only from individuals who are 18 years and older. The Body Donation Program can accept or decline a donation at the time of death. The most common reasons, but not all, for decline are recent unhealed surgeries, autopsy, history of communicable disease, physical condition of the decedent (extensive trauma/decomposition), pathology that inhibits adequate preparation procedures or unhealthy body mass index. If a donation is declined at the time of death, the next of kin/authorizing agent is responsible for making an alternate arrangement for final disposition. The Body Donation Program is not responsible for any expenses associated with alternate arrangements. Autopsies are not performed by the Body Donation Program and there is no formal report of findings released pertaining to studies.

Procedure for Completing Form: There are two different procedures for donation. Preregistration by the donor (Form 1) or registration by next of kin/authorizing agent (Form 2). All self-consenting donors must have decision-making capacity at the time they complete the consent form (Form 1). Please complete the following pages of the applicable consent form, including the consent signature portion in the presence of two witnesses. If an authorizing agent is completing Form 2, please send a copy of the health care directive or other document designating your ability to make decisions in regards to final disposition along with the completed consent form. Completed consent forms should be submitted to:

OHSU Body Donation Program, Mailcode L-341
3181 SW Sam Jackson Park Road
Portland, Oregon 97239
Fax: 503-418-0588
Email: donation@ohsu.edu

Once the Body Donation Program receives the consent form, an acknowledgment letter will be sent notifying you of our receipt. A donor, or in certain situations, an authorizing agent, may amend or revoke their consent for anatomical donation. Certain restrictions apply for amendment or revocation of a consent for donation. For questions call 503-494-8302.

At the Time of Death: To report a death call: 503-494-8302. Our staff is available M-F 8AM- 3PM. Outside of these hours, follow the instructions on the messaging system to connect with our answering service. At the time of notification, a medical assessment is performed to determine donor eligibility. This procedure is best done with hospital/caretaker staff but can be completed with a family member depending on their comfort level.

If a donor is accepted by the OHSU Body Donation Program transportation will be arranged from the place of death to our facility. If the death occurred outside of Benton, Clackamas, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington, Yamhill, Clark, Cowlitz, Klickitat, or Skamania county there will be a variable transportation fee for the service. To find out what fee is applicable to the county of death, please call our office. Our transportation service will contact the next of kin in the days following the death to gather biographical information to assist in filing the death certificate. If a donor has an existing pre-arrangement or a funeral is going to be used, please contact the funeral home and share our information with them.

If a donor is not accepted, alternate arrangements with a funeral home will be the responsibility of the next of kin/authorizing agent.



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**Form 1: Enrollment Form for Individual Donating to OHSU’s Whole Body Donation Program
Donor Information: (Please Print Legibly)**

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____ Sex: ____ Social Security #: _____

Veteran, branch: _____ Marital Status: ___ Single ___ Widowed ___ Married

If veteran please send copy of DD214 with consent form

If married, name of spouse: _____

Next of Kin Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Authorizations: (Please Read Carefully and Initial Where Appropriate)

I hereby authorize OHSU:

- (1) ___ To keep my remains for an indefinite period (no remains will be returned)
- (2) ___ To return remains as soon as studies are completed
(usually no less than 18 months, no more than 3 years)
- (3) ___ To permanently retain my brain and soft tissues for teaching collection
(remainder to be cremated and returned if #2 is selected in addition to #3)

Disposition of Remains: (Initial One of the Four Options)

I hereby direct and authorize the release/delivery or shipment of said remains as follows:

- (1) ___ Do **NOT** cremate my remains. Release body to: _____ Funeral Home
(I understand my Next of Kin will be responsible for expenses)
- (2) ___ Cremate my remains and deliver to _____ Cemetery for the
purpose of inurnment. (I understand my Next of Kin will be responsible for expenses)
- (3) ___ Cremate my remains. Remains will not be returned and OHSU will inter in a shared gravespace
for whole body donors in a cemetery of OHSU’s choice (OHSU does not charge for this service)
- (4) ___ Cremate my remains and return to:

(Name/Relationship and Address)



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Consent:

- I understand that by completing this Enrollment Form, I am authorizing OHSU to accept and use my body, or transfer it to a qualified institution, for medical education & research purposes and that upon my death, my body may be embalmed, dissected/disarticulated or plastinated for permanent preservation.
- I understand that certain laboratory and diagnostic testing will be performed and, as mandated by, law results may be reported to the Oregon Health Authority.
- I understand that the Body Donation Program may provide a donated body to other educational or research institutions for medical education or research purposes. Under the Anatomical Gift Act, when the Body Donation Program provides the donated body to an education or research entity outside of OHSU, the entity will reimburse OHSU for its reasonable costs of removal, processing, preservation, quality control, storage, transportation or cremation of the body.
- I understand and authorize the Body Donation Program to acquire and retain images related to specific medical education and research studies with the understanding that care will be taken to protect identity and dignity, and images will be acquired only when necessary to document and demonstrate scientific findings.
- I understand that a donor or next of kin/authorized agent cannot select the use or user of the anatomical donation.
- I understand and agree that the Body Donation Program's ability to return cremated remains, may be affected by weather, road conditions, and other things beyond its control, and that OHSU and persons acting on its behalf will not be responsible for any such delay.
- I understand my body may not be accepted for donation at the time of death. I understand that if this situation arises my next of kin/authorizing agent will be required to make alternate arrangements for final disposition of the body at their expense.
- I agree that a copy of this Enrollment Form is valid as an originally signed Enrollment Form.
- I understand that I may amend or revoke a donation at any time prior to death.
- I acknowledge that I am at least 18 years of age and competent to make decisions on my own behalf and that I have signed this Enrollment Form in the presence of at least two adult witnesses.

Authorized Signature:

I acknowledge that I have read (or had read to me) this document in its entirety. I have had the opportunity to ask questions, have had my questions answered, and I fully understand this document. By signing below, I consent to the donation and disposition of my remains as described above. In signing below, I represent myself as the Donor named on this form.

Signature of Donor

Date



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Signature of Witnesses:

Two witnesses must sign this form to abide by your wishes to donate to OHSU. One of the two witnesses **must be** a “disinterested witness,” meaning someone **other than**:

-A spouse, domestic partner, child, parent, sibling, grandchild, grandparent, extended relative or guardian of the donor; or

-An adult who exhibited special care and concern for the donor; or

-A representative of an institution (including a hospital, accredited medical school, dental school, college, university) or organization (including an organ procurement organization, eye bank, tissue bank)

By signing below, I declare that the person listed above, signed this enrollment form in my presence and that he/she appeared to be of sound mind and not acting under duress, fraud or undue influence. Please print the information legibly.

Witness Signature

Witness Signature

Full Name of Witness

Full Name of Witness

Witness Relationship

Witness Relationship

Street Address

Street Address



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Form 2: Enrollment Form for the Next of Kin/Authorizing Agent to Bequeath a Body on Behalf of an Individual to OHSU's Whole Body Donation Program

Donor Information: (Please Print Legibly)

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____ Sex: _____ Social Security #: _____

Veteran, if so branch: _____ Marital Status: ___ Single ___ Widowed ___ Married
If veteran please send copy of DD214 with consent form

If married, name of spouse: _____

Next of Kin Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Authorizations: (Please Read Carefully and Initial Where Appropriate)

I, as the next of kin/authorized agent named above, hereby authorize OHSU:

- (1) ___ To keep the remains of the person named above for an indefinite period
(no remains will be returned)
- (2) ___ To return remains of the person named above as soon as studies are completed
(usually no less than 18 months, no more than 3 years)
- (3) ___ To permanently retain the brain and soft tissues of the person named above for a teaching collection (remainder to be cremated and returned if #2 is selected in addition to #3)

Disposition of Remains: (Initial One of the Four Options)

I hereby direct and authorize the release/delivery or shipment of said remains as follows:

- (1) ___ Do NOT cremate the remains. Release body to: _____ Funeral Home
(I understand Next of Kin/Authorizing Agent will be responsible for expenses)
- (2) ___ Cremate the remains and deliver to _____ Cemetery for the purpose of inurnment. (I understand Next of Kin/Authorizing Agent will be responsible for expenses)
- (3) ___ Cremate my remains. Remains will not be returned and OHSU will inter in a shared gravespace for whole body donors in a cemetery of OHSU's choice (OHSU does not charge for this service)
- (4) ___ Cremate the remains and return to:

(Name/Relationship and Address)



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Consent:

- I acknowledge that I am authorized to make this donation on behalf of the person named above and understand that I may need to provide the health care directive or other documentation designating my authority to make the donation.
- I acknowledge that I am not aware of any record signed or otherwise made by the person named above refusing to make an anatomical gift.
- I authorize by completing this enrollment form that I am allowing OHSU to accept and use the body or transfer it to a qualified institution for medical education and research and upon the death of the person named above, the body may be embalmed, dissected/disarticulated or plastinated for permanent preservation.
- I understand and authorize the Body Donation Program to acquire and retain images related to specific medical education and research studies with the understanding that care will be taken to protect identity and dignity, and images will be acquired only when necessary to document and demonstrate scientific findings.
- I understand that a donor or next of kin/authorized agent cannot select the use or user of the anatomical donation.
- I understand and agree that the Body Donation Program’s ability to return cremated remains, may be affected by weather, road conditions, and other things beyond its control, and that OHSU and persons acting on its behalf will not be responsible any such delay.
- I understand the donated body may not be accepted for donation at the time of death. I understand that if this situation arises the next of kin/authorizing agent will be required to make alternate arrangements for final disposition of the body at their expense.
- I agree that a copy of this Enrollment Form is valid as an originally signed Enrollment Form.
- I understand that I may amend or revoke a donation only as authorized by law.
- I acknowledge that I am at least 18 years of age and that I have signed this Enrollment Form in the presence of at least two adult witnesses.
- I understand that certain laboratory and diagnostic testing will be performed and, if mandated by law, results may be reported to the Oregon Health Authority.
- I understand that the Body Donation Program may provide a donated body to other educational or research institutions for medical education or research purposes. Under the Anatomical Gift Act, when the Body Donation Program provides the donated body to an education or research entity outside of OHSU, the entity may reimburse OHSU for its reasonable costs of removal, processing, preservation, quality control, storage, transportation or cremation of the body.

Authorized Signature:

I acknowledge that I have read (or had read to me) this document in its entirety. I have had the opportunity to ask questions, have had my questions answered, and I fully understand this document. By signing below, I consent to the donation and disposition of the remains as described above. In signing below, I represent myself as the Next of Kin/Authorizing Agent named on this form.

Signature of Next of Kin/Authorizing Agent Date

Full Name/Relationship Phone

Address



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Signature of Witnesses:

Two witnesses must sign this form to abide by your wishes to donate to OHSU. One of the witnesses **must be** a “disinterested witness,” meaning someone **other than**:

-A spouse, domestic partner, child, parent, sibling, grandchild, grandparent, extended relative or guardian of the donor; or

-An adult who exhibited special care and concern for the donor; or

-A representative of an institution (including a hospital, accredited medical school, dental school, college, university) or organization (including an organ procurement organization, eye bank, tissue bank)

By signing below, I declare that the person listed above, signed this enrollment form in my presence and that he/she appeared to be of sound mind and not acting under duress, fraud or undue influence. Please print the information legibly.

Witness Signature

Witness Signature

Full Name of Witness

Full Name of Witness

Witness Relationship

Witness Relationship

Street Address

Street Address



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Frequently Asked Questions:

Q: Are there any conditions which would invalidate my donation?

A: The most common, but not all reasons for decline, are an unhealthy body mass index, extensive trauma, signs of decomposition, or history of communicable disease. Acceptability for whole body donation can only be determined at the time of death. To avoid undue grief and disappointment to members of your family, they should be aware of these conditions.

Q: Am I guaranteed that my body will be accepted into the program?

A: No. Acceptability for whole body donation can only be determined at the time of death after a medical assessment is completed. An alternate plan should be in place with a funeral home in the event that a body donation is not accepted.

Q: Will my body be used for teaching or research? Will my family receive a report of the findings?

A. Our program does not perform autopsies and no reports are given. The primary mission of our program is to support anatomy education to medical, dental, and other allied health students. Minimal research is supported by our program at this time. Anatomy education is the foundation of a student's medical knowledge and one of their primary courses during their first year of medical school. Students are not knowledgeable enough at this stage to recognize or diagnose diseases or conditions. Donors can also aid in continuing education opportunities for practicing residents, physicians and surgeons to learn new surgical approaches and device deployment.

Q: Can I be assured that my remains will be handled properly?

A. Yes. All donors are treated with the greatest respect, in accordance with the highest ethical standards and in full compliance with federal and state laws and regulations including the Oregon Anatomical Gifts Act. All students receive an orientation prior to working with donors; embalming and storage areas are restricted to authorized personnel only.

Q: What happens when the studies or teaching is completed?

A. Donors are cremated in the crematorium at the OHSU School of Medicine (unless specified differently on the enrollment form) and the cremated remains are returned as specified by the donor or family.

Q: How long will it be before my family receives the remains for final disposition?

A. The length of time for final disposition can be up to three years.

Q: Can I change my mind?

A. Yes. The Enrollment Form is a legal document, but it may be amended or cancelled by the donor at any time by a phone call or letter to the Body Donation Program requesting that the form be removed from the file.

Q: Does the designation of "D for Donor" on my license enroll me in the program?

A. No. A driver's license may be coded with a "D" for donor but this license designation only qualifies someone for tissue and organ donation. Eligibility for the Body Donation Program requires a separate registration form to be completed by the potential donor, the donor's next of kin or authorized representative.

Q: Can a donor choose to donate his organs before donating to OHSU's Body Donation Program?

A. Due to the possible extensiveness of organ procurement it may make a potential donor ineligible to our program. Donation to our program after any organ or tissue donation will be determined on a case to case basis at the time of death.

Q: Is there a memorial service for the donors?

Yes. Oregon Health and Science University conducts an annual memorial service commemorating donors to our program. The next of kin or authorized representative will be notified of the date, time and place of the memorial service.

Q: What is an indefinite donation?

A. Indefinite donors may be used for educational or research purposes outside of the three year range. The remains of indefinite donors will not be returned to the next of kin or authorizing agent but will be cremated and placed in a shared gravespace of OHSU's selection.

Q: Is any money paid to be a donor?

A. No. Federal Law prohibits the buying and selling of tissue or bodies donated for transplant, research or medical education.



**Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence**
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity/ facility disclosing information)

(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here for a paper copy. This release is regarding:

(Name of individual)

consisting of: (see back side for definitions) Physician reports X-rays (please see the back side of this form for complete instructions) Labs ED Billing
 Other, specify _____

If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) _____

to: _____
(Name of recipient)

(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure) Continued Care Legal Disability
 School Entry Other, specify _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information
_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

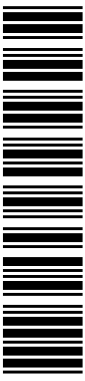
I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) 5 years after my death

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____





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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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Patient Identification

DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775) The form may be accessed at the following web site: <http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf>
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

Adult Psychiatry
Allergy & Immunology
Anticoagulation
Audiology
Bone & Mineral
Bone Marrow Transplant / Leukemia
Cardiology
Casey Eye Institute
CDRC Eugene
Center for Women's Health
Child and Adolescent Psychiatry
Childhood Development and Rehabilitation (CDRC)
Comprehensive Pain Center
Dermatology
Dermatology Surgery
Diabetes
Digestive Health
Doernbecher Pediatrics - Westside
Employee Health
Endocrinology
Executive Health
Family Medicine at South Waterfront
Gabriel Park
Gastroenterology
General Pediatrics
General Surgery
GI / Hepatology
Health Promotion and Sports Medicine
Hematology / Oncology

Infectious Disease
Intercultural Psychiatry Program
Internal Medicine
Knight Cancer Center/Community Hematology
Oncology
Lipids
Liver Transplant
Marquam Hill Internists
Nephrology & Hypertension
Neurology
Neurosurgery
Oral & Maxillofacial Surgery
Orthopaedics
Otolaryngology
Pediatric Hematology / Oncology
Pediatric Specialties
Perinatal
Plastic Surgery
Pulmonary
Radiation Oncology
Renal Transplant
Rheumatology
Richmond
Riverplace
Scappoose
Sleep Medicine
Surgical Oncology
Urology
Vascular Surgery