BioGift Anatomical Inc., 17819 NE Riverside Parkway Suite C, Portland, OR 97230

Phone 503-670-1799 ~ Fax 503-670-1834

INSTRUCTIONS FOR COMPLETING FORM 5.2.F1

It is important that you read and understand all elements of the donation process prior to completing this form. This form does not need to be notarized. Donor and witnesses must be at least 18 years old. Two witnesses are required to make this a valid authorization. The witnesses must be disinterested parties. Instruction for areas designated by numbers is as follows:

1. ***Print your full legal name.***
2. ***Print the address of where you currently reside. Please note that your residing address may be different from your mailing address. Please include your ZIP Code.***
3. ***Donor must initial that they have read all of the elements of the authorization, which includes "I understand that," "I state and affirm," and "I authorize to." (If you did not download this authorization from our website, the "I understand that" section is printed below).***
4. ***This is the signature line requiring your signature.***
5. ***Date your signature. The date must include day, month and year.***
6. ***Print your complete mailing address including ZIP Code. This may be different than your residing address.***
7. ***Telephone number. This allows us to quickly communicate with you if something is missing from your authorization.***
8. ***Witness #1 must sign and print their name. Witness #1 must be present when donor signs.***
9. ***Witness #1 must date their signature. The date must include the day, month and year.***
10. ***Witness #2 must sign and print their name. Witness #2 must be present when donor signs.***
11. ***Witness #2 must date their signature. The date must include the day, month and year.***

The signature page must be returned to BioGift Anatomical. This document may be delivered and returned by way of mail, facsimile, or email and the signatures shall be considered original and binding on the party signing as conclusive evidence of his or her signature, as if such signatures were original signatures. Please make a copy of the completed form. It is recommended that the copy be kept with your important papers or given to the individual(s) who will oversee your estate.

I UNDERSTAND THAT:

1. **In order for BioGift Anatomical to maximize the use of my body, extensive surgical dissections and disarticulations must occur. Cells, fluids, specimens, organs, tissues, and connected tissues both large and small, will be obtained from my body from these surgical procedures. The nature of these procedures will reduce my body from its original size and/or shape.**
2. **There is *NO GUARANTEE* that my body will be accepted into BioGift Anatomical's program as certain diseases, risk of diseases, or circumstances may occur to make my body unsuitable for this purpose.**
3. **Both not-for-profit and for-profit medical research and education entities compensate BioGift Anatomical for recovery, preparation, testing, storage, distribution and recordkeeping services using my body, cells, fluids, specimens, organs, tissues, connected tissues to facilitate the process.**
4. **In order for BioGift Anatomical to maximize the use of my body, it may be necessary to make available cells, fluids, specimens, organs, and tissues to researchers and educators in other countries if they cannot be placed in the United States.**
5. **In strictest confidence, BioGift Anatomical will obtain and review copies of my medical record. Someone from BioGift Anatomical will talk to my family or decision maker about my medical history.**
6. **There will be no cost to my estate for any necessary actions or procedures involved to implement this authorization for the use of my body.**
7. **BioGift Anatomical will not be obligated to pay or compensate myself or any member of my family for the use of my body.**
8. **To help BioGift Anatomical better serve the family and seamlessly coordinate the arrangements upon my death, BioGift Anatomical must be called immediately. We are available 24 hours a day, 7 days a week, 365 days a year and respond within minutes of being contacted.**
9. **Financial charges unrelated to facilitating the use of my body will be the responsibility of my estate.**
10. **I have the right to rescind my authorization to BioGift Anatomical at any time and for any reason.**

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AUTHORIZATION FOR USE OF MY WHOLE BODY UPON DEATH

I,_____**(1)**
Print your full name

residing at,_____**(2),**

upon my death, authorize BioGift Anatomical, to freely direct or perform all of the necessary steps, procedures and preparatory requirements to enable my body to be used for supporting medical education/research and/or medical scientific purposes.

I state and affirm that:

1. **I am at least 18 years old.**
2. **I am of sound mind.**
3. **I want my body to be used for medical education/research and/or medical scientific purposes to benefit humanity.**
4. ***My initial* signifies that I have read the "I understand that" section located on the instructions side of this form. [_____] Initial (3)**
5. **I agree that the part of my body not procured or used for medical education/research and/or medical scientific purposes to be deemed my body and cremated as its final disposition by any state licensed or authorized crematory.**
6. **I agree that all procured cells, bodily fluids, specimens, organs, tissues, and connected tissues both large and small be deemed as such and to be medically cremated in any authorized facility after their medical use as required/authorized by applicable state or federal law, and returned to no one.**

I authorize BioGift Anatomical:

1. **To direct the preparation and transfer of my body upon my death to BioGift Anatomical, or any designated facility/location and by any means necessary in their sole discretion within the confines of applicable state and federal law.**
2. **To release my vital statistics information which is necessary to have a death certificate and transportation permit filed with the county or state where my death occurs as required by law.**
3. **To perform a blood draw from my body so that infectious communicable disease testing may take place to include HIV and Hepatitis B/C, or the release of serological test results for infectious communicable disease testing from a third party to BioGift Anatomical.**
4. **The release of any/all of my medical information and my medical record including autopsy results (if performed) to BioGift Anatomical to be held in strictest confidence.**
5. **To perform surgical dissection and disarticulation of my whole body as BioGift Anatomical sees fit in their sole discretion, to maximize and facilitate the use of my body for medical education and/or medical scientific purposes.**
6. **To distribute my cells, fluids, specimens, organs, tissues, and connected tissues large and small that originated from my body for medical research/education and/or medical scientific purposes as accepted by BioGift Anatomical for such medical purposes (both domestically and internationally) at BioGift Anatomical's sole discretion.**
7. **To manage/direct the authorized cremation of my body using the services of any state licensed or legally authorized crematory.**
8. **To manage/direct the cremation of my cells, fluids, specimens, organs, tissues or connected tissues large and small originating from my body after its intended medical research/educational use, following all state and/or federal applicable regulations/laws established for anatomical material cremation, and the cremated remains returned to no one.**

_____ **(4)**_____**(5)**
Signature of Authorizing Individual **Date**

_____**(6) (_____)**_____ **(7)**
Complete Mailing Address of Authorizing Individual **Daytime Phone Number**

_____**(8)**_____**(9)**
Witness 1 Printed Name **Witness 1 Signature** **Date**

_____**(10)**_____**(11)**
Witness 2 Printed Name **Witness 2 Signature** **Date**