FOR DONORCURE® USE ONLY
Validated by: ____________________
Signature ____________________
Date ____________________

605 SE 1st Ave, Suite D, Delray Beach, FL 33444

AUTHORIZATION OF BODY GIFT

This form must be completed by the donor, health agent or legal next of kin. Incomplete or inaccurate forms will be returned for corrections and can delay the donor approval process.

Donor's Full Legal Name: ____

(Legal name as reflected on the donor's Social Security records. Include Jr., Sr., II, III, etc. if applicable)

The prospective donor is: (Please check as applicable)

- ☐ currently receiving hospice care
- ☐ has a life expectancy of six months or less

Donor's Date of Birth (mm/dd/yy):
____ /____ /____

I understand that

- this whole-body donation gift is motivated exclusively by altruistic intentions without financial compensation or valuable consideration made to me or any family member.
- an autopsy will NOT be performed to determine the cause or contributing factors that led to the death of the donor.
- no guarantee has been given that this donation will benefit a specific use, research, or educational study. This donation may benefit multiple educational, scientific, organ procurement and medical research organizations, for profit or nonprofit, domestic or international, and the education or research institution may perform final specimen disposition.
- determination of acceptance of donation will be made at the time of passing. DONORCURE® reserves the right, at their sole discretion, to decline acceptance of the donation and related charges if it appears unsafe or unsuitable for the purposes consented to herein.
- upon acceptance of donation, DONORCURE will be responsible for any costs related to the donation including transportation, cremation, obtaining a copy of the donor's death certificate, and return of cremated remains to the family or a scattering of cremated remains at sea.
- the donor's body will be transported to a DONORCURE facility. All protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) will remain confidential and be kept in a secure location.
- an open casket viewing is not possible with whole body donation and no un-cremated remains will be returned. The cremated remains returned will not include body tissues, organs, or anatomical specimens procured for medical education or research purposes.
- DONORCURE and all associated agents, including specimen end-users, shall not be liable from loss or damage, including incidental and consequential damage which results from the undersigned not having proper legal authority to consent.
- signing this document does NOT guarantee acceptance of donation
- Any material misrepresentation of body condition or medical history causing the donor to be unacceptable for donation may result in the donor family or consenter being responsible for any costs incurred by DonorCure, Inc.

I hereby authorize

- the procurement of all necessary tissues, organs, and anatomical specimens, including whole body, for medical research and educational purposes and understand tissue/specimens may be used indefinitely into the future. I understand that the body may be subject to extensive preparation and/or long-term preservation, including but not limited to, removal of the head, arms, fingers, legs, toes, hands, feet, spine, organs, tissues, or fluids both domestically and internationally.
- for any and all medical information to be released to DONORCURE before or after death, including but not limited to, a complete medical history and blood samples. Blood testing may occur which can include, but is not limited to, HIV, hepatitis B and hepatitis C. Positive blood test results for HIV will be communicated to the Health Department. A positive result for HIV, hepatitis B or hepatitis C will also be communicated to the next of kin.

I further authorize this whole body donation for additional education and research uses, such as weapons testing and personal protective gear (for example military); search, rescue, and recovery operations; forensic pathology and crime scene investigation; educational display; plastination (permanent plastic fixation of body tissues); or automobile safety research. In some cases, such research or education may involve destruction of the body or parts of the body. **Yes** ☐ **No** ☐

Please Send Death Certificate to (name): ______________________ Phone Number: __________
Relationship to Donor: ______________ Address: ______________________
City: ______________ State: ______________ Zip Code: __________

I hereby confirm that I understand and consent to all the above-listed disclosures as indicated by my signature below:

Signature of Consenter: __________ **Print Name:** ______________________

Relationship to the donor: ☐ self ☐ health agent ☐ spouse ☐ adult child ☐ parent ☐ sibling
☐ other relative (fill in relationship __________) ☐ estate representative

Date Signed: __________ **Address:** ______________________
City: ______________ **State:** ______________ **Zip Code:** __________

Two witnesses must affix their signatures too. Witnesses cannot be the person consenting to donation and must be 18 years or older. At least one witness must also be a "disinterested party" (not a spouse, child, sibling, parent, grandchild, grandparent, or legal guardian of the prospective donor).

Signature of Witness #1: ______________	**Signature of Witness #2:** ______________
Print Name: ______________	Print Name: ______________
Phone Number ______________	Phone Number ______________
Date Signed: ______ Relationship to Donor: ______	Date Signed: ______ Relationship to Donor: ______

FOR DONORCURE® USE ONLY
Validated by: ____________________
Signature ____________________
Date ____________________

DONORCURE®
YOUR ANGELS GIFT FOR LIFE
605 SE 1st Ave, Suite D, Delray Beach, FL 33444

CREMATION AUTHORIZATION

This form must be completed by the donor, health agent or legal next of kin. Incomplete or inaccurate forms will be returned for corrections and can delay the donor approval process.

Donor's Full Legal Name: ____

(Legal name as reflected on the donor's Social Security records. Include Jr., Sr., II, III, etc. if applicable)

Donor's Date of Birth (mm/dd/yy):
____ /____ /____

Date of Death (mm/dd/yy): (if applicable)
____ /____ /____

This is to authorize DONORCURE® and its affiliated crematory, hereinafter referred to as "crematory", to cremate the body of the above-named donor subject to applicable regulations and the following disclosures.

I understand that:

- the crematory may place the body in a rigid enclosed container for sanitary purposes.
- dental fillings, bridgework, gold inlays, prostheses, jewelries and other non-organic items shall be removed from the body and discarded
- the cremation process normally involves pulverizing and grinding the cremated remains
- the cremated remains that are returned to the family or scattered at sea may or may not represent all the tissue of the donor.
- some parts of the cremated remains that are deemed irreclaimable during the cremation and containerization cannot be returned to the family
- the cremated remains will be placed in a standard sized container; any excess shall be placed in a supplementary container and will be returned to the family together with the primary container.
- this consent form does not constitute a contract of service with DonorCure and its affiliates but an expression of informed consent for the purpose herein stated
- the cremation process shall be conducted in accordance with all applicable laws of this country and the state with which the cremation has taken place
- the cremated remains shall be returned by way of express mail; otherwise it will be scattered at sea subject to DonorCure's discretion and applicable internal policies.

I hereby agree that DonorCure along with its employees, contractors, agents, and affiliates (including but not limited to the crematory and beneficiary medical research facilities) is released from all liabilities, claims, and damages arising from the reliance or performance of the conditions and disclosures stated herein.

Does donor have a pacemaker? ☐ Yes ☐ No

Has the donor had any intravenous or surgically implanted radiation treatments? ☐ Yes ☐ No

Does the donor have any dental implants or prostheses? ☐ Yes ☐ No

DISPOSITION OF CREMATED REMAINS

☐ Please return cremated remains to: ______________________________________
Street Address: ____________________________ City: ______________
State: ____________________________ Zip Code: ____________________
Contact No.: ____________________________ Email: ____________________

☐ Please dispose of the remains at sea
☐ Notify Next of Kin ☐ Do not notify Next of Kin

☐ My remains can be used for research and education indefinitely

Upon my oath and under penalty of perjury, I hereby certify to the best of my knowledge all information presented herein is correct and that no other person is previously authorized to give permission for the cremation and disposition of the donor's remains. To verify my consent and understanding to the terms and conditions herein stipulated, I hereby affix my signature.

Signature of Consenter: ______________ **Print Name:** ______________________________

Relationship to the donor: ☐ self ☐ health agent ☐ spouse ☐ adult child ☐ parent ☐ sibling
☐ other relative (fill in relationship ____________ ☐ estate representative

Date Signed: ______________ **Address:** ______________________________________

City: ____________________ **State:** ____________________ **Zip Code:** ________

Two witnesses must affix their signatures. Witnesses cannot be the person consenting to donation and must be 18 years or older. At least one witness must also be a "disinterested party" (not a spouse, child, sibling, parent, grandchild, grandparent, or legal guardian of the prospective donor).

Signature of Witness #1: ____________________	**Signature of Witness #2:** ____________________
Print Name: ____________________	Print Name: ____________________
Phone Number ____________________	Phone Number ____________________
Date Signed: ________ Relationship to Donor: __________	Date Signed: ________ Relationship to Donor: __________

FOR DONORCURE® USE ONLY
Validated by: ______________________
Signature ______________________
Date ______________________

DONORCURE®
YOUR ANGELS GIFT FOR LIFE
605 SE 1st Ave, Suite D, Delray Beach, FL 33444

VITAL INFORMATION FORM

IMPORTANT NOTICE:
Please ensure that all information disclosed in this form is accurate and matches legal records. Any inaccuracies such as misspelled or unreadable words can invalidate the death certificate. Please write legibly in CAPITAL letters. For questions with no determinable answer, please write "UNKNOWN".

Donor's Full Legal Name: ____
(Legal name as reflected on the donor's Social Security records. Include Jr., Sr., II, III, etc. if applicable)

Maiden or Prior Name (if applicable): ____

PERSONAL INFORMATION OF DONOR

Date of Birth: ______________ **City and State of Birth:** ______________________ **Gender:** __________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: ______________________

Spouse's Full Name (must include maiden name if applicable): ______________________________

Social Security No.: ______________________ ☐ I prefer to provide it over the phone

Highest Education Level: ______________________

Occupation (do not enter "retired") ______________________ **Industry:** ______________________

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American or Alaskan Native
☐ Native Hawaiian ☐ Other Native Pacific Islander

Of Hispanic Origin: ☐ Yes ☐ No

Is the donor a Veteran? Yes ☐ No ☐ **Branch** ______________

Has the Donor ever been diagnosed with cancer? ☐ Yes ☐ No

Donor's Current Residence:

Street Address: ______________________________ City: ______________ ☐ In City Limits?

County: ______________________________ State: ______________________ Zip Code: ________

How long has the deceased been living in this address? ______________

Permanent Residence: ☐ Same as current residence

Street Address: ______________________________ City: ______________ ☐ In City Limits?

County: ______________________________ State: ______________________ Zip Code: ________

Father's Name: ______________________________ **Birthplace:** ______________________

Mother's Name: ______________________________ **Birthplace:** ______________________

Mother's Maiden Name: ______________________________

I certify that the information provided above are true and correct to the best of my knowledge. DonorCure, its employees, and affiliates are hereby released from any claims and liabilities arising from erroneous representation of any information in this form. In witness whereof, I hereby affix my signature:

Signature of Person providing information: ______________ **Print Name:** ______________________

Date Signed: ______________ **Address:** ____

City: ______________________ **State:** ______________________ **Zip Code:** __________

Phone ______________________ **E-Mail** ______________________________

Questions? Call 800-928-8233