



University of  
**Kentucky**

**College of Medicine**  
Office of Medical Education  
*Willed Body Program*

## The *Gift* of Knowledge

Guide for Making Anatomical Gifts to the University of Kentucky

MORTUI VIVOS DOCUERUNT

*“Dead they have taught the living.”*

CONTENTS

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Information Regarding Body Donation .....	2
Procedures at Time of Death .....	2
Instructions for Donation Forms .....	5
Attachments:	
FORM: Authorization to Donate Decedent to the University of Kentucky College of Medicine	
FORM: Vital Statistics Information	
FORM: Donor Medical History Information	
FORM: Change of Information	

## Gratitude to Donors and Their Families

Thank you for the interest you have shown in donating your loved one's body to the University of Kentucky College of Medicine Willed Body Program. The University of Kentucky is profoundly grateful to anatomical donors and their families for their contributions to medical education and research. Without your generous gift the study and research of human anatomy would not be possible for our students.

## The Importance of Anatomical Donations

Anatomical donations are essential to medical education and research. Anatomy courses rely on anatomical donations to give students first-hand knowledge of the anatomical structures of the human body. These courses are among the first, and most important, in the education of physicians, dentists, nurses, physical therapists, and other health professionals.

Anatomical donations are also essential to advanced anatomy studies and research. Physicians in residency programs, practicing physicians, biomedical scientists, and others depend on anatomical donations to support new advancements in medical science.

All members of the medical community who rely on anatomical donations, from students in core anatomy courses to professionals in advanced research areas, are greatly indebted to anatomical donors and their families for making their work possible.

Donors and their families may find comfort in the knowledge that dignity and respect for those who have donated their bodies are maintained at all times. The indispensable contribution that participants in the Willed Body Program have made is fully recognized. The laboratory is restricted and is only authorized for use by students, faculty, staff, and professionals of medical, dental, health sciences, and related professions.

## Anatomical Gifts and the Law

The State of Kentucky first enacted legislation governing anatomical donations in 1942, and most recently developed the Kentucky Revised Uniform Anatomical Gift Act in 2010. These statutes reside within Chapter 311 of the Kentucky Revised Statutes. The most recent revisions help ensure that the wishes of the donor continue to be protected. The Willed Body Program is governed by these statutes.

## Procedures at the Time of Death

### Procedures for Making an Anatomical Gift of a Decedent that Did Not Pre-Register Prior to Death

If a person passes without donating their body, the closest next of kin or legal representative may donate the decedent to the Willed Body Program by completing the proper donation forms. **The closest next of kin or legal representative must contact the Willed Body Program directly as soon as possible to notify us of the intent to donate, and to receive the proper forms needed to facilitate and expedite the donation.** To document the intent to make a gift, the Willed Body Program has created the following attached Donor Authorization forms:

- Authorization to Donate Decedent
- Authorization for Cremation
- Vital Statistics Information
- Medical History Information

The **original signed** forms must be sent to the Willed Body Program. Please retain copies of the forms for the decedent's estate records. The gift becomes effective immediately upon death but is subject to conditions at the time of death and acceptance by the Willed Body Program. **These forms must be received by the Willed Body Program prior to transporting the body to the Willed Body Program.**

The University of Kentucky utilizes a contracted mortuary service for the acquisition, preparation, and delivery of the body to the Willed Body Program. Once the signed forms are confirmed to be received by the Willed Body Program, the family, funeral home, or other representative of the donor should arrange promptly to contact the University's contracted service provider for transportation:

Kentucky Mortuary Services  
104 Dennis Drive  
Lexington, KY 40503  
(859) 278-8501

If death occurs outside of Fayette County, there may be additional transportation charges that are the responsibility of the donor's estate. Family or other representatives should call Kentucky Mortuary Services to coordinate delivery and to discuss any possible transportation charges.

### **Death Occurring Outside of Kentucky**

We recommend that a donor's body be donated to a recipient in the state where death occurs. If the donor is already registered within the program and dies out-of-state, immediately contact Kentucky Mortuary Services to determine if the donation is still a possibility. Several factors may prohibit the delivery and acceptance of the body to the Willed Body Program. For this reason, if a death occurs outside of Kentucky, it is likely the Willed Body Program will not be able to accept the donor into the program due to a delay in the time to receive a donor such as transportation, legal issues, and coordination with a local funeral home at the place of death.

### **Acceptance into the Program**

If the Willed Body Program accepts the donation of an individual's body, the family can expect the body to remain in the program for several years. Due to the nature of the study, the Willed Body Program is unable to return a body to the family at the end of the study. All donors of the program will be cremated immediately at the end of the study. The ashes will be dispersed of and honored according to the original declaration in the Authorization for Cremation section of the signed donation package.

If the Willed Body Program declines or refuses the donation of an individual, it is the obligation of the donor's estate to make final arrangements. Individuals who are considering body donation may wish to make funeral pre-arrangements with their local funeral director in the event the Willed Body Program is not able to accept the body.

### **Disposition of Ashes**

Following the study of the donor's body, the remains will be cremated. The included form, "Authorization for Cremation," contains the selection for the disposition of ashes. These are: burial at the University of Kentucky Memorial Burial Grounds at Lexington Cemetery, shipment of ashes to a specific directed recipient, or to be picked up in person from Kentucky Mortuary Services in Lexington, KY.

**Interfaith Memorial Service**

Each year an Interfaith Memorial Service will be held by the Willed Body Program. Each service will memorialize multiple donors who have decided to donate their body to the program. Faculty, staff, and students attend and participate in this service to publicly express their appreciation for the donors who have been studied. The closest next of kin will be invited to attend this service if they choose to be notified. The Interfaith Memorial Service will not include graveside services.

**Financial Responsibility**

There is no cost to the donor's estate if the decedent is successfully accepted into the program with the possible exception of charges for transporting the body from the place of death outside of Fayette County to Kentucky Mortuary Services. These possible costs are through our contracted mortuary service, Kentucky Mortuary Services, and should be discussed with them at the time of notification of death. A physical assessment will be conducted prior to transportation. If the decedent is unable to be accepted into the Willed Body Program, the decedent will become the responsibility of the family or estate.

## Instructions to Complete the Decedent Donation Package Forms

Please complete all forms included in this package. These forms are mandatory for acceptance into the Willed Body Program and are used to assist us in the donation of your loved one's body. All registration forms must be completed and signed where indicated. Keep the information portion of this package for your reference but send the original completed and signed forms to the Willed Body Program office. It is recommended that you make a copy of the registration forms for your records.

### **Form: “Authorization to Donate Decedent to the University of Kentucky College of Medicine”**

**This form must be received by the Willed Body Program prior to transporting the body to the Willed Body Program.**

This form is required by the state of Kentucky authorizing the University of Kentucky to accept the donation without charge or payment. Please fill this form out completely. It is important to read and understand Part D, “Acknowledgement of Conditions,” and to initial each condition to acknowledge your understanding and agreement.

- **Authorization for Cremation (Part E of the Authorization to Donate Decedent to University of Kentucky College of Medicine form)**

This information is used by funeral services to allow for cremation after the study period has ended. You must initial each acknowledgement line in this form and select the option for the final disposition of the ashes. If your disposition option is other than a burial, ensure to let the person you selected to receive the ashes know of your wishes. If the contact information changes for this person, the Willed Body Program will need to be notified as soon as possible. If the information is incorrect, and after multiple contact attempts, the ashes will be buried in our memorial burial grounds.

### **Form: “Vital Statistics Information”**

This information is mandatory and needed to complete and process the death certificate with the State of Kentucky, Office of Vital Statistics. All sections must be completed to the best of your ability. If you do not have the information for an item, write “Unknown” or “None” in that space. Do not leave any blank sections. Please PRINT all information.

### **Form: “Donor Medical History Information”**

The information provided is of great value to the teaching and research of our program. It helps to give an insight into areas of the body that may be of special interest for study. Please complete this information as honestly, accurately, and as detailed as possible. This information, as with all the donor information, remains confidential and is protected under HIPAA (Health Insurance Portability and Accountability Act) laws.

### **Form: “Change of Information”**

It is not uncommon for contact information to change over time. It is important to inform the Willed Body Program when this happens. Please use the “Change of Information” form to notify us of any changes. You may contact our office as well to receive a new form. The form must be signed by the surviving closest next of kin or authorized representative of the donor to prevent improper changes. Please send this completed form to the Willed Body Program’s office whenever there is a change to any contact information or a change to the closest next of kin.



Authorization to Donate Decedent to the University of Kentucky College of Medicine

Please complete this form if you wish to donate a decedent to the University of Kentucky College of Medicine and have the authorization to do so under Kentucky law (KRS 311.1925).

Part A: Decedent

Name: (First) (Middle) (Last) (Suffix) Maiden Name:
Street: City: State: Zip:
County:
SSN: Date of Birth: Date of Death:
Marital Status: Married Divorced Widowed Never Married
Spouse's Name: (First) (Middle) (Last) (Suffix)
Home Phone: Cell Phone: Email:

Part B: Authority to Make Donation (For example, the donor's (1) agent at time of death, (2) Spouse, (3) Adult Children, (4) Parents, (5) Adult Siblings, (6) Adult Grand Children, (7) Grandparents, or (8) other persons acting as guardian for the decedent at the time of death).

Relationship to the decedent:
Name: (First) (Middle) (Last) (Suffix)
Street: City: State: Zip:
Home Phone: Cell Phone: Email:

Part C: 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 - Closest) Name: (First) (Middle) (Last) (Suffix) Relationship:
Street: City: State: Zip:
Home Phone: Cell Phone: Email:
(2nd-Secondary) Name: (First) (Middle) (Last) (Suffix) Relationship:
Street: City: State: Zip:
Home Phone: Cell Phone: Email:

Part D: Acknowledgment of Conditions (Please initial each blank line to indicate acknowledgement of that condition).

- I confirm that I have the legal authority to make this donation.
I understand the decision to accept my body will not be determined until after the event of my death and a physical assessment has been conducted.
I understand that the Willed Body Program will only be responsible for the cost of local county transportation of my remains from place of death to the program; death certificate preparation fee; cremation; return of the cremains within the United States or burial in UK cemetery grounds for all donors accepted into the program.
Transportation costs (if any) outside of Fayette County may be the responsibility of next of kin or my estate.
Transportation arrangements should be made with Kentucky Mortuary Services.

- \_\_\_\_\_ The acceptance of these forms does not constitute a contract with University of Kentucky, University of Kentucky College of Medicine, University of Kentucky Willed Body Program, and/or Kentucky Mortuary Services.
- \_\_\_\_\_ I understand that the Willed Body Program will not perform an autopsy and, therefore, will not release a report to family members pertaining to educational or research findings.
- \_\_\_\_\_ I understand that the exact use of my anatomical gift will be at the discretion of the Willed Body Program. I understand that my body may be used for education, general research, and/or to further innovative technologies.
- \_\_\_\_\_ I understand my body may be used by the Willed Body Program, other health centers, or educational or research institutions approved by the University of Kentucky and the Willed Body Program.
- \_\_\_\_\_ I understand that I will need to contact the Willed Body Program with any information to be updated (contact information, next of kin contact/designation, marital status, etc.) for my donation to remain current.
- \_\_\_\_\_ I authorize my name to be disclosed at the annual Memorial Service.
- \_\_\_\_\_ I understand that I may withdraw from the Program at any time prior to death by sending a signed and dated letter to the Willed Body Program. A letter of confirmation from the Willed Body Program will be returned.
- \_\_\_\_\_ I understand that I am responsible for sharing my decision to donate, and all policies of the program with my family.
- \_\_\_\_\_ I understand the following restrictions may prevent the acceptance of my body into the Program:
- Infectious diseases such as HIV, tuberculosis, hepatitis, MRSA, VRE, flesh-eating disease, West Nile virus, and Creutzfeldt-Jakob disease
  - Other contagious diseases based on the opinion of the Willed Body Program physician consultant
  - Obesity (greater than 225 Pounds) or extreme emaciation (a BMI greater than 30 or less than 16 are limiting factors)
  - Suffered a violent death, victim of suicide, or homicide
  - An autopsy has occurred
  - Amputations, open wounds, or incisions
  - Any stage IV decubitus (bed sores) or presence of gangrene
  - Vital organs removed for transplantation purposes (other than corneas)
  - Recent treatment with therapeutic radionuclides
  - Constraint in any non-prone position
  - Any conditions that would impede proper embalming
  - Any other restrictions as outlined in the Willed Body Program Physical Assessment form

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**Part E: Authorization for Cremation and Final Disposition** (Please initial each blank line to indicate your acknowledgement for each statement).

- \_\_\_\_\_ I understand the length of time the decedent may be in the program could last from 6 months up to several years.
- \_\_\_\_\_ I understand that after completion of the program, the decedent's body will be cremated. The Willed Body Program is unable to return the whole body to any designated recipient.
- \_\_\_\_\_ I understand the Willed Body Program will arrange for cremation and final disposition of decedent's ashes as directed.
- \_\_\_\_\_ I understand the Willed Body Program will, unless otherwise directed, arrange for burial of decedent's ashes at the UK Memorial Burial Grounds located at Lexington Cemetery, 833 W Main St, Lexington, KY 40508.
- \_\_\_\_\_ I understand that any other burial direction, other than the UK Memorial Burial Grounds, must be made in advance, and will become the sole financial and arrangement responsibility of the decedent's estate.
- \_\_\_\_\_ I understand that the Willed Body Program will only pay for shipping of ashes within the United States via Certified USPS Mail. All shipping charges and official documents for other countries are the responsibility of the decedent's estate.
- \_\_\_\_\_ I understand the Willed Body Program will attempt to contact the designated recipient of my ashes prior to shipping or pick up. If unable to contact recipient, or if ashes are to be picked up but are not claimed after 90 days of successful notification, my ashes will be buried in the UK Memorial Burial Grounds.





I request the disposition of decedent's ashes as indicated below:

- I wish to have the decedent's ashes buried in the UK Memorial Burial Grounds at the expense of the University.
I wish to have the decedent's ashes mailed at the expense of the University to the following recipient:

Name of Recipient Address, City, State, Zip

Phone Email Address

- I wish to have the decedent's ashes picked up by the following recipient:

Name of Recipient Address, City, State, Zip

Phone Email Address

Part F: Donor Attestation / Witness

Two (2) different individual signatures are required. If possible, the witness signature is preferred to be the closest Next of Kin. If a Medical/Health Care Power of Attorney (POA) is signing for a donor, please include a copy of the applicable signed POA form.

I have read and fully understood the policies set forth in this document. As the legally responsible party for:

(Name of Decedent), I wish to donate his/her remains to the University of Kentucky, College of Medicine, Willed Body Program. I accept all terms and conditions set forth in this document and I know of no express, contrary information indicating that the decedent would not want to donate his/her body.

I have read, understand, and agree to the conditions for donation of the decedent's body to the Willed Body Program as stated in Section D. I further understand and agree that acceptance of the decedent's body into the program will be determined at the time of death, and, that the program reserves the right to refuse any donation.

Pursuant to the provisions of laws relating to the Revised Uniform Anatomical Gift Act contained within KRS Chapter 311, I hereby give, donate, grant, and bequeath the decedent's body for teaching, research, and therapeutic use of the University of Kentucky College of Medicine. University of Kentucky College of Medicine reserves the right to decline to accept a bequeathed body for any reason.

By signing below, I am also giving authorization to release the decedent's medical records to the College of Medicine and Willed Body Program.

Signature of Authorized Person Making Donation of Anatomical Gift

Date

Relationship to the Decedent

Witnessed:

Printed Name of Witness

Signature of Witness

Date



Vital Statistics Information

The following information is mandatory to complete the Death Certificate. Please fill out the information as best as possible.

Date Completed: \_\_\_\_\_

Full Name as it appears on Social Security Card: \_\_\_\_\_

First Middle Last; Include Suffix if Applicable (Jr., Sr., II, III, etc.)

Maiden Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex: [ ] Male [ ] Female

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_
Month/Day/Year City, State or Foreign Country

Current Address: \_\_\_\_\_ County: \_\_\_\_\_
House Number, Street, City, State and Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Veteran of the U.S. Armed Forces? [ ] Yes [ ] No | Branch: [ ] Army [ ] Navy [ ] Air Force [ ] Marines [ ] Coast Guard [ ] Space Force

Type of Discharge / Separation: [ ] Honorable [ ] General Under Honorable Conditions [ ] Other Than Honorable [ ] Dishonorable

Current Marital Status: [ ] Married [ ] Divorced [ ] Widowed [ ] Never Married [ ] Separated [ ] Unknown

Spouse's Full Name as it appears on Social Security Card: \_\_\_\_\_ Spouse's Maiden Name
First Middle Last; Include Suffix if Applicable (Jr., Sr., II, III, etc.)

Highest Level of Education Completed (Check only One of the following):

- [ ] 8th Grade or Less [ ] 9th through 12th Grade, No Diploma [ ] High School Diploma or GED [ ] Some College, but No Degree
[ ] Associate Degree (e.g. AA; AS) [ ] Bachelor's Degree (e.g. BA; BS) [ ] Master's Degree (e.g. MA; MS) [ ] Doctorate or Professional Degree

Occupation (Most of Working Years): \_\_\_\_\_ Kind of Business/Industry: \_\_\_\_\_

Father's Full Name (Even if Deceased): \_\_\_\_\_
First Middle Last; Include Suffix if Applicable (Jr., Sr., II, III, etc.)

Mother's Full Name (Even if Deceased): \_\_\_\_\_ Mother's Maiden Name
First Middle Last

Race / Ethnicity (Information is used to assist demographic research involving health problems and trends of population groups and is required information on the Death Certificate.)

Hispanic Origin?

(Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino.)

- [ ] No, not Spanish/Hispanic/Latino
[ ] Yes, Mexican, Mexican American, Chicano
[ ] Yes, Puerto Rican
[ ] Yes, Cuban
[ ] Yes, Other Spanish / Hispanic / Latino
Specify: \_\_\_\_\_

Decedent's Race

(Check one or more races to indicate what the decedent considered himself or herself to be)

- [ ] White [ ] Samoan
[ ] Black or African American [ ] Other Asian
Specify: \_\_\_\_\_
[ ] Native Hawaiian [ ] Other Pacific Islander
Specify: \_\_\_\_\_
[ ] Asian Indian [ ] American Indian or Alaska Native
(Name of the enrolled or principal tribe): \_\_\_\_\_
[ ] Chinese [ ] Other
Specify: \_\_\_\_\_
[ ] Filipino
[ ] Japanese
[ ] Guamanian or Chamorro
[ ] Korean
[ ] Vietnamese

## Donor Medical History Information

Donor's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Donor medical histories are a very important part of our studies. To aid us in obtaining a complete medical record, please fill in the information to the best of your knowledge and check all that apply below:

Sex: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (Pounds): \_\_\_\_\_

### Has the donor had any of the following diseases or conditions?

- Sepsis       Hepatitis       HIV/AIDS       C. diff (*Clostridium difficile*)  
 TB (Tuberculosis)       Decubitus Ulcers       Jaundice       Covid-19 (Coronavirus)  
 Active MRSA (Methicillin Resistant *Staphylococcus aureus*)       Active VRE (Vancomycin Resistant Enterococci)  
 Dementia first diagnosed: \_\_\_\_\_       Multiple Systems Atrophy (MSA)  
 Other Contagious Disease(s): \_\_\_\_\_  
 Skeletal Anomalies (Explain): \_\_\_\_\_  
 Fractures (List Bone and Year): \_\_\_\_\_  
 Head Injury / Concussion (How Many, Type, and Year(s)): \_\_\_\_\_  
 Arthritis: \_\_\_\_\_  
 Cancer (Type(s)): \_\_\_\_\_ Treatment(s)/ Year(s): \_\_\_\_\_

### Has the donor had any of the following surgeries?

- Heart Surgery (Year): \_\_\_\_\_       Spine Surgery (Year): \_\_\_\_\_       Colostomy (Year): \_\_\_\_\_  
 Appendix Removed (Year): \_\_\_\_\_       Gall Bladder Removed (Year): \_\_\_\_\_       Tonsils Removed (Year): \_\_\_\_\_  
 Pacemaker (Model/Year(s)): \_\_\_\_\_       Other Organ Removed (Type/Year): \_\_\_\_\_  
 Joint Replacement Surgery (Joint(s)/Year Year(s)): \_\_\_\_\_  
 Amputation(s) (Location): \_\_\_\_\_  
 Other Surgical History: \_\_\_\_\_

### Female Donors

- Hysterectomy (Year): \_\_\_\_\_       Number of Children Birthed: \_\_\_\_\_       Cesarean Section Year(s): \_\_\_\_\_

### Dental History (Check all that apply)

- Lower Dentures       Upper Dentures       Partial Dentures       Fixed Bridge       Braces       Implant(s)       Crown(s)  
 Wisdom Teeth Removed (How Many): \_\_\_\_\_       Jaw Surgery       Few Teeth Missing       Many Teeth Missing       All Teeth Missing

### Donor Social Activities

- Smoker (How Many Packs/Week): \_\_\_\_\_ How Many Years: \_\_\_\_\_  
 Alcohol (How Much /Week): \_\_\_\_\_ How Many Years: \_\_\_\_\_  
 Marijuana (How Much /Week): \_\_\_\_\_ How Many Years: \_\_\_\_\_ Types Used: \_\_\_\_\_  
 Other Drug Use (Type, How Often, How Long): \_\_\_\_\_  
 Substance Abuse (Explain Type, How Often, How Long): \_\_\_\_\_

\_\_\_\_\_  
Signature of Donor or Legal Authority to Make a Donation

\_\_\_\_\_  
Relationship to Donor  
(Donor/Agent of Donor/Guardian/Medical  
or Health Care POA)

\_\_\_\_\_  
Date



Donor Number: \_\_\_\_\_

Registration Number: \_\_\_\_\_

## Change of Information

### USE THIS FORM ONCE YOU ARE REGISTERED TO CHANGE INFORMATION

To report a change of address, phone number, marital status, designated Next of Kin, or other pertinent information, please complete this form and return it to the UK Willed Body Program. Accuracy in reporting changes helps ensure that data will be recorded correctly.

Donor's Name: \_\_\_\_\_ Donor's Registration Number: \_\_\_\_\_

**Change in Donor's Address and/or Contact**

Former Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Current Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Change in Primary Next of Kin and/or Contact Information**

Name of Former Primary Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Former Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Current Primary Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Current Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Change in Marital Status:**     Widowed     Married     Divorced     Re-Married

**Change in Married Name:** \_\_\_\_\_

**Change in/Addition of Spouse's Name:** \_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Donor or Legal Authority to Make a Donation

\_\_\_\_\_  
Relationship to Donor  
(Donor/Agent of Donor/Guardian/Medical  
or Health Care POA)

\_\_\_\_\_  
Date