GIFT OF BODY (GOB)
DONATION & REGISTRATION FORM SET

(6 pages, single-sided)

***PLEASE PRINT OR TYPE * (blue or black ink only)**

This form must be completed & returned to register for the program.

____

Print Donor's Full Name

PLEASE LIST LIVING FAMILY MEMBERS (Spouse, Children, Siblings, Parents, etc.):

NAME	RELATION	PHONE #	COMPLETE MAILING ADDRESS

I, ______________________________________ agree to each of the following statements:
*(**Print Donor's Full Name**)*

Initial each statement indicating understanding and agreement.

X__________ I understand and agree to the conditions for donation of my body to the University of South Carolina School of Medicine (USC SOM) in Columbia, SC upon the event of my death, as laid out in the Gift of Body Donation and Registration Form Set as provided by the Gift of Body Program.

X__________ I understand and agree that initial acceptance of my donation intent ***does not*** guarantee final acceptance into the program and that my donation intent will be subject to confirmation/refusal by Gift of Body Program personnel at the time of my death. (*see FAQ sheet for reasons for possible refusal of donation*)

X__________ I understand that it is my responsibility to contact the GOB program with any information to be updated (change of address, next-of-kin designation, marital status, etc.) for my donation intent to remain current.

X__________ I understand that I may change my mind at any time and cancel my donation intent by means of signed letter written to the program. The program will mail confirmation of any cancellation to the donor at the last address noted.

X__________ I understand that I ***may choose*** to donate my body permanently to USC SOM. To do so I ***must*** complete page 5 of this form set. If I select this, I understand my cremated remains will not be available for return to my family should I choose this option for Permanent Donation.

____________________ ______________________________________

Month / Day / Year **Donor Signature Required** (POA accepted with documentation)

This form must be completed & returned to register for the program.

Pursuant to the provisions of the Uniform Anatomical Gift Act of the State of South Carolina (South Carolina Code Annotated. 44-43-310 through 44-43-400, 1976, as amended),

I, ______________________________ being of sound mind and over the age of eighteen (18) years,
(Print donor's full name)
do hereby, effective at the time of death, give my entire body to the University of South Carolina School of Medicine Gift of Body Program in Columbia, SC for the purposes of medical teaching and research. The Gift of Body Program at the University of South Carolina reserves the right to use the donation here or at other health-related schools or hospitals.

*If you prefer that your donation be used only at U.S.C., please inform us in writing. *

Cremation and disposition of remains will be the responsibility of the University of South Carolina School of Medicine.

Signing this document acknowledges that you, the donor, have read and understand all the attached instructions.

Executed before the below listed witnesses on this day, ______________________________
(Month / Day / Year)

____
(Signature of donor)

______________________________ ______________________________
(Social security number) ***(Phone number)***

____
(Complete mailing address)

____

FIRST WITNESS

____
(Print name of first witness) ***(Relationship)***

____
(First witness address and phone number)

____

____
(Signature of first witness) ***(Month/Day/Year)***

SECOND WITNESS

____
(Print name of second witness) ***(Relationship)***

____
(Second witness address and phone number)

____

____
(Signature of second witness) ***(Month/Day/Year)***

This form must be completed & returned to register for the program.

Information obtained on this form is used to complete the state certified death certificate. Please be as accurate and thorough as possible. Please indicate "Unknown" instead of leaving the space blank.

FULL NAME (as it appears on Social Security Card):____

SOCIAL SECURITY # ______________________________

SEX ASSIGNED AT BIRTH: MALE__ FEMALE__ OTHER/INTERSEX__

GENDER: MAN__ WOMAN__ NON-BINARY__ OTHER__

PRONOUNS: he/him/his__ she/her/hers they/them/theirs__ OTHER__

DATE OF BIRTH_____________________________ CITY/STATE/COUNTRY OF BIRTH____________________________

PHYSICAL ADDRESS – (Street Address, Apt # as needed, City, State & Zip Code) **Do Not Put "Mailing Address"**

____

INSIDE CITY LIMITS? _____ COUNTY _______________ SERVED IN US ARMED FORCES: Y__ N__

MARITAL STATUS___________________ APPROX. HEIGHT _________ APPROX. WEIGHT ___________

SURVIVING SPOUSE FULL NAME (Give middle name. Provide maiden if applicable):

____

FATHER (**FIRST, MIDDLE, LAST**)____

MOTHER (**FIRST, MIDDLE, *MAIDEN***)____

NEXT-OF- KIN NAME & RELATIONSHIP____

NEXT-OF-KIN CONTACT INFORMATION____

NAME OF EXECUTOR OR POWER OF ATTORNEY (Note which) – Include Address & Phone # ______________________

____

DONOR WISH ON CREMAINS: (***check one***) ____ Return to Family (NOK) OR ___To be interred by USC

EDUCATION (Highest level completed – **Select one**): ☐ 8th grade or less ☐ 9th – 12th grade, no diploma
☐ High school graduate or GED completed ☐ Some college, but no degree ☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng., Med, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

DONOR OF HISPANIC ORIGIN? (Select One) ☐ ***NOT*** Spanish/Hispanic/Latino/Latina ☐ Puerto Rican ☐ Cuban
☐ Mexican, Mexican American, Chicano/Chicana ☐ Other (Specify) ________________________________

DONOR'S RACE (**Check one or more** races to indicate what the donor considers themself):
☐ White ☐ Black or African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Other Pacific Islander (Specify) ________________ ☐ Other Asian (Specify) ________________________
☐ American Indian or Alaska Native (Name of enrolled or principal tribe) ______________________________
☐ Other (Specify) ______________________

OCCUPATION DURING CAREER (Do NOT use Retired) _______________________________________

TYPE OF BUSINESS/INDUSTRY (***Be Specific***)____

OPTIONAL: ADDITIONAL BIOGRAPHICAL INFORMATION

This information is voluntary. The information provided is kept confidential and is intended for our students to get to know who you are, as it is important for them to know and understand their first patient. Please feel free to answer all, some, or none of the following questions.

"NEW" FIRST NAME: ____

To keep your anonymity, we do not provide the students with your first or last names.
If you would like to, please select a "new" first name or nickname that the students may call you.

HOBBIES/INTERESTS: ____

____

FAVORITE MOVIE(S): ____

____

FAVORITE BOOK(S): ____

____

FAVORITE SONG(S)/MUSIC: ____

____

WHEN YOU WERE YOUNGER, WHAT DID YOU WANT TO BE WHEN YOU GREW UP? ____________

____

ABOUT YOU or ANY WORDS:
If you would like, please let us know anything else you would like to share with the students about you: words of advice, why you have selected to selflessly donate to their education, favorite quote, etc.

____

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OPTIONAL: PERMANENT ANATOMICAL DONATION RELEASE FORM

Completion of page 5 indicates cremated remains will NOT be returned to the family

Pursuant to the provisions of the Uniform Anatomical Gift Act of the State of South Carolina (South Carolina Code Annotated. 44-43-310 through 44-43-400, 1976, as amended),

I, ____ hereby donate my body to the
(Print donor's full name)

University of South Carolina School of Medicine Gift of Body in Columbia, SC and their **Polymer Preservation Program**, to be utilized in any manner that is deemed necessary and appropriate.

Initial each statement indicating understanding and agreement.

X________I understand that such use may involve demonstration of anatomical structures for educational purposes within or external to the University of South Carolina.

X________I also authorize the release of my medical information and history to the University of South Carolina School of Medicine Gift of Body Program.

X________I also would like to make it known that the University of South Carolina School of Medicine has permission to ***permanently*** keep my body, and I completely understand that my body or my ashes ***will not be returned*** to the family upon completion of the study period.

X________I understand that at such time as study is completed on my body that the cremated remains will be interred by the University of South Carolina School of Medicine.

Signing this document acknowledges that you, the donor, have read and understand all the attached instructions.

Executed before the below listed witnesses on this day, ______________________________________
(Month / Day / Year)

____
(Signature of donor)

FIRST WITNESS

____
(Print name of first witness) ***(Relationship)***

____
(First witness address and phone number)

____

____
(Signature of first witness) ***(Month/Day/Year)***

SECOND WITNESS

____
(Print name of second witness) ***(Relationship)***

____
(Second witness address and phone number)

____

____
(Signature of second witness) ***(Month/Day/Year)***

<u>OPTIONAL ENROLLMENT</u>: PERMISSION TO INCLUDE X-RAYS, FILMS, SCANS

Imaging Permissions:

The medical images will be used in correlation with the anatomy gift. These images enhance the medical students' experience by allowing them to gain a more in-depth look on how images are used to make clinical decisions. Many of these are detailed CT and MR scans, along with X-rays and Ultrasound scans that help demonstrate greater detail of the human body, which we will supplement to the education experience.

All donated images are maintained in computer files and are identified by an ID number associated with the number of the anatomy gift. ***Please note: Images will not be requested until death of the donor.***

____

(Print donor full name)

I agree to grant access to any medical imaging studies I have had performed, and that the images may be used anonymously in conjunction with the Polymer Preservation Program. I hereby give permission to any Medical Records or Radiological Departments to share this information with the Gift of Body Program at USC School of Medicine in Columbia, SC.

___________________________________ ________________

(Donor Signature) ***Month / Day / Year***

At the time of filing, my most recent imaging (x-ray, MRI, CT scan, ultrasound, etc…) were performed at the following locations:

List type of imaging, location (hospital or practice) and date.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Additional imaging can be reported at any time, to update the file.
Please call (803) 216-3888 to do so.