UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799
www.usuhs.edu

September 28, 2022

SUBJECT: Body, Organ, and Tissue Donations

Instruction 6464

(MDL)

ABSTRACT

This Instruction provides information on the policies concerning body, organ, and tissue donation in the Department of Defense (DoD) and the Uniformed Services University of the Health Sciences (USU). In addition, this Instruction outlines the duties of key people at the USU in making these donor programs available to the faculty, staff, and students.

A. Reissuance and Purpose. This Instruction reissues USU Instruction 6464 (*Reference (a)),* implements DoD Directive 6465.3 (*Reference (b)*) and Estate and Trust Title 4 (*Reference (c)*), and establishes the USU policies and procedures relative to the donation of bodies, organs, and tissues for transplantation or biomedical teaching and research.

B. References. *See Enclosure 1.*

C. Applicability. This Instruction applies to all USU personnel involved in donor programs, but emphasizes on the Department of Multidisciplinary Laboratories (MDL), Anatomical Teaching Laboratories (ATL).

D. Definitions. *See Enclosure 2.*

E. Policy. It is USU policy to.

1. Incorporate DoD policies regarding organ and tissue donations into the MDL. These applicable policies:

a. Encourage interested personnel to consider whole body donation after death from all beneficiaries of the DoD health care system. This gift is done without coercion, or the appearance of coercion, of perspective donors or their next of kin;

b. Establish reasonable procedures for anyone interested in body donation to complete a donor application, be accepted and carry a body donation card titled, "Instructions for Body Disposition," and

ANATOMICAL
GIFT PROGRAM

UNIFORMED SERVICES UNIVERSITY
F. EDWARD HÉBERT SCHOOL OF MEDICINE
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4712

CERTIFICATE OF BODY DONATION

UNIFORMED SERVICES UNIVERSITY

Being at least 18 years of age and of sound mind, I hereby state that it is my/the wish to donate my/the body immediately following my/the death to the Uniformed Services University of the Health Sciences for medical education, medical research, medical science as are permitted by law.

This gift shall be independent of any Will I may have and shall not be revoked by a revocation of my/the Will or by any other document unless this gift is specifically mentioned and revoked thereby. The Uniformed Services University shall not be held accountable for acting pursuant hereto unless a timely written notice of revocation by me/NOK shall have been delivered to the University upon receipt of notice of revocation, the University shall return this instrument or any copy thereof to me.

Since autopsy, embalming or organ donation other than to the University may limit the use of my body for certain medical studies, I request that only under special circumstances may these procedures be performed and then only after the prior consent of the University has been obtained. I understand that the University may, in its discretion, decline to accept this donation, and that if my body is accepted when death occurs outside a 150-mile radius of Washington, D.C., the costs of transportation must ordinarily be borne by my survivors or my estate.

It is the condition of this gift that when the anatomical studies have been completed, my body, or next of kin's body will be cremated unless other arrangements are agreed to by the University. _____ initial (s)

_____ DATE

_____ SIGNATURE OF DONOR

_____ CITY AND STATE WHERE CERTIFICATE COMPLETED

_____ NAME (PLEASE TYPE OR PRINT CLEARLY)

_____ STREET ADDRESS

_____ CITY STATE ZIP

WITNESSES

_____ SIGNATURE OF WITNESS (1)

_____ SIGNATURE OF WITNESS (2)

_____ NAME

_____ NAME

_____ CITY STATE ZIP

_____ CITY STATE ZIP

_____ PHONE NUMBER

_____ PHONE NUMBER

CONSENT TO ANATOMICAL GIFT BODY TO UNIFORMED SERVICES UNIVERSITY

I, the undersigned next of kin to _____ do hereby consent to the DONATION of my relative following his/her death. I agree to the transfer of his/her intact body to the Uniformed Services of the Health Sciences. Next of kin, in order of priority: 1. surviving spouse, 2. adult son or daughter, 3. either parent, 4. adult brother or sister, 5. guardian, 6. other authorized person or agency as provided by law. See §4-501 et. seq., MD code Annotated.

_____ DATE

_____ SIGNATURE OF NEXT OF KIN

_____ RELATIONSHIP TO DONOR

_____ NAME (PLEASE TYPE OR PRINT CLEARLY)

Learning to Care for Those in Harm's Way

The Uniformed Services University
Anatomical Gift Program

Medical History and Research Assessment Questionnaire
SAB ID: _____

Donor Name: _____

Person completing form: _____ Relationship to donor: _____

Note: The person completing this form should answer ALL questions YES or NO, "to the best of your knowledge; comment and elaborate on all questions marked YES.

1. Do you feel you know (Donor Name) well enough to answer questions regarding his/her medical and social history?	☐ Yes ☐ No
2. Weight and Height of Donor	_____Weight. _____ Height.
3. Has (he/she): A. Been treated by a physician in the past two years?	☐ Yes ☐ No
B. Been hospitalized in the past two years? *Why ?*_____ _____ _____	☐ Yes ☐ No
4. Did (he/she): A. Have any serious illnesses or infections in the past? *What type and when?* _____ _____ _____	☐ Yes ☐ No
B. Have any surgical procedures in the past? *What type and when?* _____ _____ _____ _____	☐ Yes ☐ No
5. Has (he/she) ever been diagnosed with the following contagious illnesses?	
A. HIV or AIDS	☐ Yes ☐ No
B. Hepatitis B	☐ Yes ☐ No
C. Hepatitis C	☐ Yes ☐ No
D. Tuberculosis	☐ Yes ☐ No

6. Did (he/she) ever use non-prescribed drugs, "street" drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants, heroin? ☐ Yes ☐ No
*List type used, how much, when, and by what route (injected, smoked, snorted, etc).*_____

7. Did (he/she) ever drink alcoholic beverages? ☐ Yes ☐ No
List type, amounts, and length used: _____
_____

8. Did (he/she) ever use tobacco products? ☐ Yes ☐ No
Amount, *and length used.*_____
_____

9. Did (he/she) ever receive blood transfusions or blood products? ☐ Yes ☐ No
When and why? _____

10. Was (he/she) ever refused as a blood donor or told not to donate? ☐ Yes ☐ No
When and why? _____

11. In the past twelve months did (he/she) have any of the following?
A. Tattoo? ☐ Yes ☐ No
B. Ear / Body piercing? ☐ Yes ☐ No
C. Acupuncture? ☐ Yes ☐ No
D. Accidental needle stick? ☐ Yes ☐ No

12. Was (he/she):
A. Vaccinated or immunized for any reason in the past twelve months? ☐ Yes ☐ No
Type and when? _____
B. Vaccinated for Hepatitis B? ☐ Yes ☐ No

13. Did (he/she) have any history of:
A. Heart disease? ☐ Yes ☐ No
B. High blood pressure? ☐ Yes ☐ No
C. Chest pain? ☐ Yes ☐ No
D. Varicose veins or poor circulation? ☐ Yes ☐ No

14. Did (he/she) have any kidney related disease(s) and/or dialysis treatments? ☐ Yes ☐ No
Type, when, how long? _____
_____

15. Did (he/she) have a history of diabetes? ☐ Yes ☐ No
Type, how long, name of medication? _____
_____

16. Did (he/she) have a history of:
A. Digestive or intestinal problems? ☐ Yes ☐ No
Type, how long, treatment? _____
_____
B. Bloody Stools? ☐ Yes ☐ No
C. Recent weight loss? ☐ Yes ☐ No
How much? _____
D. Colectomy or colon recesection surgery? ☐ Yes ☐ No

17. Has (he/she) ever had cancer (including skin cancer)? ☐ Yes ☐ No

Type of Cancer: _____
*Number of years without recurrence?*_____

18. Has (he/she) ever been diagnosed with any type of autoimmune disease? ☐ Yes ☐ No
*Type, when diagnosed, treatment?*_____
_____

19. Did (he/she) have a medical diagnosis of:
A. Osteoporosis? ☐ Yes ☐ No
B. Arthritis? ☐ Yes ☐ No
C. Broken Bones? ☐ Yes ☐ No
*When, location of break?*_____

20. Did (he/she) have a history of skin infections such as leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases? ☐ Yes ☐ No
*Type, location, when, treatment?*_____
_____

21. In the past twelve months has (he/she) ever been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes, or venereal warts? ☐ Yes ☐ No
*Type, when, treatment?*_____
_____

22. Has (he/she) ever been an inmate (confined to lockup, jail, or prison) for an extended period of time? *When, how long?*_____ ☐ Yes ☐ No
_____

Question 23 is for ONLY FEMALE DONORS

23. Has she ever had any of the following?
A. Hysterectomy ☐ Yes ☐ No
B. Tubal Ligation ☐ Yes ☐ No
C. Caesarean Section ☐ Yes ☐ No
D. Bladder Surgery of any kind? ☐ Yes ☐ No
Type_____

24. Did (he/she) have a history of diseases, infections, or surgeries involving the eyes such as glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery? ☐ Yes ☐ No
*Type, how long, treatment, reason for surgery?*_____
_____

Question 25 is for POTENTIAL NEUROLOGICAL AND PSYCHIATRIC RESEARCH (Brain Tissue Studies)

25. Did (he/she) suffer from any type of neurological or brain disease such as:
For "yes" responses, provide explanation.

A. Alzheimer's or other dementia? _____	☐ Yes	☐ No
B. Encephalitis? _____	☐ Yes	☐ No
C. Parkinson's? _____	☐ Yes	☐ No
D. Degenerative Neurological Disease? _____	☐ Yes	☐ No
E. Multiple Sclerosis (MS)? _____	☐ Yes	☐ No
F. ALS (Lou Gehrig's Disease)? _____	☐ Yes	☐ No
G. Brain Tumor? _____	☐ Yes	☐ No
H. Seizures? _____	☐ Yes	☐ No
I. Creutzfeldt-Jakob Disease (CJD)? _____	☐ Yes	☐ No
J. Periods of confusion, memory loss or hallucinations? _____	☐ Yes	☐ No
K. Unsteady walking or visual changes? _____	☐ Yes	☐ No
L. Clinical Depression? _____	☐ Yes	☐ No
M. Bi-Polar Disorder? _____	☐ Yes	☐ No
N. Schizophrenia or psychosis? _____	☐ Yes	☐ No
O. ADD or ADHD? _____	☐ Yes	☐ No
P. Ever treated in a psychiatric facility in the past two years?	☐ Yes	☐ No
Facility name, reason, when? _____		
_____		
If (he /she) is accepted for this research would you be willing to receive a follow-up Call from the Neurological or Psychiatric Research Department?	☐ Yes	☐ No

Additional Comments (Please refer to question numbers when appropriate):

c. Establish a system that administrates and educates those interested in body donation.

2. In addition, it is USU policy to encourage whole body donations to the USU Anatomical Gift Program (AGP) in support of the School of Medicine (SOM), School of Nursing (SON), and numerous residency medical education programs.

F. Responsibilities.

1. The Administrator of the Anatomical Gift Program (AGP) shall:

a. Ensure that DoD beneficiaries and civilian personnel that are interested in the USU AGP Program are:

1) Informed about DoD and University's AGP and its purpose, and

2) Provided convenient access to literature and appropriate forms pertaining to AGP, including "Instructions for Body Disposition," *Enclosure 3*, and "Certificate of Body Donation," *Enclosure 4*.

b. If the patient or Next of Kin of a patient at Walter Reed National Military Medical Center (WRNMMC) is considering body donation, they must coordinate with the WRAMMC Decedent Affairs Officer (DAO) for body donation procedures. The DAO will forward the caller to contact the USU AGP Administrator for program criteria.

c. A patient may consider the completing the Five Wishes advance directive. It meets the legal requirements of 44 states, but is used widely in all 50 as a reference. The Administrator of the Uniformed Services University Anatomical Gift Program shall consider the Five Wishes request, when used in conjunction with the USU Anatomical Donation application.

d. Federal law requires medical care providers to honor patient wishes as expressed.

2. The Director, Civilian Human Resources (CHR) shall make available information about the AGP to civilian employees.

3. The Administrator, AGP, MDL shall:

a. Manage the USU AGP;

b. Provide information and forms pertaining to the AGP to the David E. Cabrera University Family Health Center (UFHC), CHR, and Military Personnel Office (MPO);

c. Respond to any inquiries about the AGP;

d. Coordinate pledges for whole body donations at the USU; and

e. Ensure timely responses to notifications pertaining to the availability of donated bodies.

G. Procedures. *See Enclosure 5.*

H. Effective Date. This Instruction is effective immediately.

Jonathan Woodson, MD, MSS, FACS
President

Enclosures:
1. References
2. Definitions
3. Sample Body Donation Card
4. Sample Certificate of Body Donation Form
5. Procedures
6. AGP Disclaimer

REFERENCES

(a) USU Instruction 6464, "Body, Organ, and Tissue Donations," dated November 8, 2010 (hereby canceled).

(b) DoD Directive 6465.3, "Anatomic Gifts and Tissue Donation," dated June 8, 2016.

(c) Annotated Code of Maryland, Estate and Trust Title 4 - Wills; Anatomical Gift Act, Subtitle 5, 2019 Supplement.

(d) Uniformed Anatomical Gift Act (UAGA), drafted by National Conference of Commissioners of Uniformed State Laws 2006 (revised).

(e) Title III of the Public Health Service Act (42 U.S.C. 421 et seq.).

(f) H.R. 4062 – Consensual Donation and Research Integrity Act of 2021.

(g) https://fivewishes.org/.

DEFINITIONS

1. Anatomical Teaching Laboratories (ATL): Laboratory located within the Uniformed Services University where anatomical body donors are stored, studied and researched.

2. Body Donor Card/Donation Form: A legal document signed by an individual and properly witnessed, stating the rules of informed consent and indicating a desire to have his/her body, or one or more tissues or organs, removed at death for donation to another individual, or for educational or research purposes.

3. Donor: The term 'donor' means a person who has knowingly consented in accordance with applicable law to the transfer of such person's deceased body or deceased or living body part (not for use in transplantation) for education, research, or the advancement of medical, dental, or mortuary science.

4. Education: The term 'education' means the use of a human body or body parts for teaching or training individuals, including medical, dental, or mortuary science students or professionals, with regard to the anatomy and characteristics of the human body, disease detection, and such other uses as may be specified.

5. Human Body: The whole body with all organs and tissues present and no autopsy performed.

6. Human Body Part: The terms 'human body part' or 'body part' mean an organ, tissue, eye, bone, blood vessel or any other portion of a deceased or living human body that is subject to an anatomical gift or other transfer made pursuant to State law, but do not include

7. Organ: For the purposes of this Instruction, this term includes, but is not limited to, the heart, lungs, liver, kidneys, and pancreas.

8. Tissue: Includes, but is not limited to, corneas, eyes, skin, bone, bone marrow, dura, blood vessels, and fascia.

SAMPLE DONATION CARD

USU
Uniformed Services University

INSTRUCTIONS FOR BODY DISPOSITION

This certifies that I have donated my body, unautopsied, unembalmed and intact for medical education and scientific research purposes. After the death has occurred, please call the number listed below for further instructions.

NAME OF DONOR

Center for Multidiscipline Services
Room: G038A
4301 Jones Bridge Road
Bethesda, MD 20814-4712

Office: 301-295-3333
301-295-3334
Fax: 301-295-3290
ronald.rivenburgh@usuhs.edu

UNIFORMED SERVICES UNIVERSITY
F. EDWARD HEBERT SCHOOL OF MEDICINE
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4712

Enclosure 4

CERTIFICATE OF BODY DONATION

UNIFORMED SERVICES UNIVERSITY

Being at least 18 years of age and of sound mind, I hereby state that it is my/the wish to donate my/the body immediately following my/the death to the Uniformed Services University of the Health Sciences for medical education, medical research, medical science as are permitted by law.

This gift shall be independent of any Will I may have and shall not be revoked by a revocation of my/the Will or by any other document unless this gift is specifically mentioned and revoked thereby. The Uniformed Services University shall not be held accountable for acting pursuant hereto unless a timely written notice of revocation by me/NOK shall have been delivered to the University upon receipt of notice of revocation, the University shall return this instrument or any copy thereof to me.

Since autopsy, embalming or organ donation other than to the University may limit the use of my body for certain medical studies, I request that only under special circumstances may these procedures be performed and then only after the prior consent of the University has been obtained. I understand that the University may, in its discretion, decline to accept this donation, and that if my body is accepted when death occurs outside a 150-mile radius of Washington, D.C., the costs of transportation must ordinarily be borne by my survivors or my estate.

The information obtained from the application will only be used for research and cadaveric laboratory use. The information provided will be redacted to protect identification of the cadaver donor at all times. The cadaver identity will not be revealed, shared, or published with any party or publication that may result from any research we may conduct.

It is the condition of this gift that when the anatomical studies have been completed, my body, or next of kin's body will be cremated unless other arrangements are agreed to by the University. _____ initial (s)

DATE _____ SIGNATURE OF DONOR_____

_____ _____
CITY AND STATE WHERE CERTIFICATE COMPLETED NAME (PLEASE TYPE OR PRINT CLEARLY)

STREET ADDRESS _____ CITY_____ STATE_____ZIP_____

WITNESSES

SIGNATURE OF WITNESS (1) SIGNATURE OF WITNESS (2)

NAME_____ NAME_____

CITY_____ STATE_____ ZIP_____ CITY_____STATE _____ZIP_____

PHONE NUMBER_____ PHONE NUMBER _____

CONSENT TO ANATOMICAL GIFT BODY TO UNIFORMED SERVICES UNIVERSITY

I, the undersigned next of kin to _____ do hereby consent to the DONATION of my relative following his/her death. I agree to the transfer of his/her intact body to the Uniformed Services of the Health Sciences. Next of kin, in order of priority: 1. surviving spouse, 2. adult son or daughter, 3. either parent, 4. adult brother or sister, 5. guardian, 6. other authorized person or agency as provided by law. See §4-501 et. seq., MD code Annotated.

DATE_____ SIGNATURE OF NEXT OF KIN _____
RELATIONSHIP TO DONOR_____ NAME (PLEASE TYPE OR PRINT CLEARLY) _____

Learning to Care for Those in Harm s Way

USU
Death Certificate Worksheet

Name of Deceased:_____

Race:_____ **Gender:**_____ **Hispanic Origin: (Y/N):**_____

Legal Address:_____

Address in City Limits: (Y/N): _____ **Social Security Number:**_____

Marital Status:_____ **Date of Birth:**_____

Place of Birth:_____ **Date of Death:**_____

City of Death:_____ **Fathers Name:**_____

Mothers Full Name (include maiden name) _____

Veteran (Y/N, Years of Service):_____

Highest Level Education Completed:_____

Occupation:_____ **Industry:**_____

Legal Informant / Relationship to Deceased:_____

Legal Informant Address:_____

Signature of Next of Kin, Verifying data as listed above:_____

NOK Phone Number:_____

The Uniformed Services University Anatomical Gift Program

Medical History and Research Assessment Questionnaire

USU ID: _____ (internal use only)

Donor Name: _____
Person completing form: _____ Relationship to donor: _____

Note: The person completing this form should answer ALL questions YES or NO, "to the best of your knowledge; comment and elaborate on all questions marked YES.

1. Donor Name: _____

2. Person completing form: _____ Relationship to donor: _____

Note: The person completing this form should answer ALL questions YES or NO, "to the best of your knowledge; comment and elaborate on all questions marked YES .

1. Do you feel you know (Donor Name) well enough to answer questions regarding his/her medical and social history? YES NO

2. Weight and Height of Donor YES NO

3. Has (he/she):
   a. Been treated by a physician in the past two years? YES NO

   b. Been hospitalized in the past two years YES NO
   Why? _____

4. Did (he/she):
   a. Have any serious illnesses or infections in the past? YES NO
   What type and when? _____
   _____
   _____

   b. Have any surgical procedures in the past? YES NO
   What type and when? _____
   _____
   _____
   _____

5. Has (he/she) ever been diagnosed with the following contagious illnesses?
   a. HIV or AIDS YES NO
   b. Hepatitis B YES NO
   c. Hepatitis C YES NO
   d. Tuberculosis YES NO

6. Did (he/she) ever use non-prescribed drugs, "street" drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants, heroin? YES NO

List type used, how much, when, and by what route (injected, smoked, snorted, etc)._____

7. Did (he/she) ever drink alcoholic beverages? YES NO
List type, amounts, and length used: _____
_____

8. Did (he/she) ever use tobacco products? YES NO
Amount, and length used: _____
_____

9. Did (he/she) ever receive blood transfusions or blood products? YES NO
When and why? _____

10. Was (he/she) ever refused as a blood donor or told not to donate? YES NO
When and why? _____

11. In the past twelve months did (he/she) have any of the following? YES NO
    a. Tattoo?
    b. Ear / Body piercing?
    c. Acupuncture?
    d. Accidental needle stick?

12. Was (he/she):
    a. Vaccinated or immunized for any reason in the past twelve months?
    b. Type and when? _____
    c. Vaccinated for Hepatitis B?

13. Did (he/she) have any history of:
    a. Heart disease?
    b. High blood pressure?
    c. Chest pain?
    d. Varicose veins or poor circulation?

14. Did (he/she) have any kidney related disease(s) and/or dialysis treatments?
Type, when, how long? _____
_____

15. Did (he/she) have a history of diabetes?
    Type, how long, name of medication? _____
    _____

16. Did (he/she) have a history of:
    a. Digestive or intestinal problems?
    Type, how long, treatment? _____
    _____
    b. Bloody Stools?
    c. Recent weight loss?
    How much? _____
    d. Colectomy or colon recesection surgery?

17. Has (he/she) ever had cancer (including skin cancer)?

Type of Cancer: _____
Number of years without recurrence? _____

18. Has (he/she) ever been diagnosed with any type of autoimmune disease? YES NO
Type, when diagnosed, treatment? _____
_____

19. Did (he/she) have a medical diagnosis of:
    a. Osteoporosis? YES NO
    b. B. Arthritis? YES NO
    b. C. Broken Bones? YES NO
    c. When, location of break? _____

20. Psoriasis, or inflammatory skin diseases? YES NO
Type, location, when, treatment? _____
_____

21. In the past twelve months has (he/she) ever been treated for any sexually transmitted Disease such as syphilis, gonorrhea, genital herpes, or venereal warts? YES NO
Type, when, treatment? _____
_____

22. Has (he/she) ever been an inmate (confined to lockup, jail, or prison) for an extended period of time? YES NO
When, how long? _____
_____

23. Question 23 is for ONLY FEMALE DONORS: Has she ever had any of the following?
    a. Hysterectomy YES NO
    b. Tubal Ligation YES NO
    c. Caesarean Section YES NO
    b. Bladder Surgery of any kind? YES NO
    Type_____

24. Did (he/she) have a history of diseases, infections, or surgeries involving the eyes such as glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery? YES NO
Type, how long, treatment, reason for surgery? _____
_____

25. Question 25 is for POTENTIAL NEUROLOGICAL AND PSYCHIATRIC RESEARCH (Brain Tissue Studies) Did (he/she) suffer from any type of neurological or brain disease such as: YES NO
For "yes" responses, provide explanation.
    a. Alzheimer's or other dementia? _____ YES NO
    b. Encephalitis? _____ YES NO
    c. Parkinson's? _____ YES NO
    d. Degenerative Neurological Disease? _____ YES NO
    e. Multiple Sclerosis (MS)? _____ YES NO
    f. ALS (Lou Gehrig's disease)? _____ YES NO
    g. Brain Tumor? _____ YES NO
    h. Seizures? _____ YES NO

i. Creutzfeldt - Jacob disease (CJD)? _____ YES NO
j. Periods of confusion, memory loss or hallucinations? _____ YES NO
k. Unsteady walking or visual changes? _____ YES NO
l. Clinical Depression? _____ YES NO
m. Bi-Polar Disorder? _____ YES NO
n. Schizophrenia or psychosis? _____ YES NO
ADD or ADHD? _____ YES NO
Ever treated in a psychiatric facility in the past two years? YES NO
Facility name, reason, when? _____
_____
o. If (he /she) is accepted for this research would you be willing to receive a follow-up YES NO
p. Call from the Neurological or Psychiatric Research Department? YES NO

Additional Comments (Please refer to question numbers when appropriate):

PROCEDURES

1. Forms and literature for organ and tissue donations will be obtained from MTC (Army/Navy Transplant Program) at WRAMC by the UFHC and distributed to CHR, MPO, and persons requesting same.

2. Forms and literature for the University's AGP will be provided by the Administrator of the Anatomical Gift Program AGP, MDL.

3. USU personnel interested in whole body donation shall contact:

a. The Administrator, AGP, MDL for forms and information pertaining to whole body donations for purposes of medical education and research; and

b. If a patient at Walter Reed National Military Medical Center, contact Decedent Affairs, Patient Administration (301-295-2216), notify them you are interested in whole body donation.

Enclosure 6

AGP DISCLAIMER

We appreciate your interest in the USU Anatomical Gift Program. Before completing the application, review the statements below and initial each as applicable. If you do not agree with the terms and conditions, your request for anatomical gift donation will be declined. Once you've reviewed our terms, I ask you complete the Certificate of Donation. You can email, fax, or mail your application. Complete as much as you can, leaving blank date and place of death. Feel free to call with any questions (301-295-3334).

1. **(Place your initials next to the appropriate statement)**

   I / the donor have not been diagnosed with COVID-19:_____

   I / the have been vaccinated for COVID-19: _____

   I / the will provide proof of COVID-19 vaccination: _____

   I / the will provide a COVID-19 negative test: _____

   I / the donor will provide photo ID for donation: _____

2. **(Certified death certificates)**

   My next of kin will pay a flat fee of $100* to file death certificates _____

   I agree to pay the per copy charge per state death certificate_____

   (Maryland $12-13)* (Virginia $12)* (West Virginia $12)* (Washington, DC $18)*

   If the death occurs in West Virginia I will pay $50* for the Cremation Permit_____

   *subject to change

3. **(Laboratory Bloodwork Screening)**

   If the donor blood panel are positive for any infectious disease, I will pay a contracted cremation fee up to $375* to USU funeral contractor_____

   Select one or more donor program option(s):

   I agree to anatomical donation up to 4 months_____

I agree to anatomical donation up to 1 year_____

I support long term research, I agree to anatomical donation up to 2 years_____

4. **(End of Program)**

My family will accept the cremated remains from USU when anatomical usage ends_____

I have selected burial or inurnment at a local, National or VA Cemetery _____

Signed: _____

Printed: _____

Date: _____ Phone: _____