COUNTY CORONER/MEDICAL EXAMINER
Whole Body Donation Authorization

FUNERAL HOME TO COMPLETE:

Decedent: ____ D.O.B.: ________________

Date of Death: _____________________________ Time of Death: __________________

Place of Death: ____

Primary Physician's Name and Clinic: ____

Phone: _________________________________ Fax: _____________________________

Funeral Home: ____

Contact: ____

Phone: _________________________________ Fax: _____________________________

Whole Body Donation Program: ____

Contact: ____

Phone: _________________________________ Fax: _____________________________

PHYSICIAN TO COMPLETE: **Please fax to: _____________________**

Date last seen or clinic visit: ____

Was there any TRAUMA that contributed to the death? Yes_______ No_______
(i.e. motor vehicle crash, fracture, falls, surgical procedures, etc.)

If yes, please describe: ____

Is there any reason to postpone or deny whole body donation? Yes______ No_______

If yes, please explain: ____

CAUSE OF DEATH AS IT WILL APPEAR ON THE DEATH CERTIFICATE:

33 Part I Line a: ____
Due to
33 Part I Line b: ____
Due to
33 Part I Line c: ____

Other Significant Conditions: ____

Physician's Signature: ___________________________________ Date: ______________

CORONER/MEDICAL EXAMINER TO COMPLETE:

Coroner/ME Signature: ____

OK to Donate Whole Body? Yes______ No______ Date: _________________