

For Office # _____
Use Only Date: _____

**Whole Body Release Form**  
 Anatomical Resource Clinical Training Center  
 Center for Experiential and Applied Learning - Wake Forest School of Medicine  
 Winston-Salem, North Carolina 27157-1039  
 336-716-4369 / **336-716-2447** (fax)

This form IS ONLY ACCEPTABLE when signed by the closest surviving family member (or verified Power of Attorney) AFTER death has occurred. It provides us with permission to release their loved one to the Wake Forest School of Medicine. It also provides us with their wishes for disposition of ashes.

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

I,  Mr.  Mrs.  Ms. \_\_\_\_\_

hereby release the body of \_\_\_\_\_  
 to the Wake Forest School of Medicine Whole Body Anatomical Bequeathal Program for use in medical education,  
 training, or research studies as determined by the Program.

I do not wish the cremated remains returned and request that the Wake Forest School of Medicine arrange final disposition.

I request that the cremated remains be returned to another person or location:  
 Other       Funeral Home (Please consider this option if time for private viewing is desired upon receipt of ashes. All arrangements must be made in advance and will be the responsibility of the family.)

\_\_\_\_\_  
 Name (and relation to deceased if applicable)

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State Zip

\_\_\_\_\_  
 Phone Number & Email

I request that the cremated remains be returned to my address below:

**Next-of-Kin (or verified Power of Attorney)**

**Witness (Non-family)**

\_\_\_\_\_  
 Name (relation to deceased)

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State Zip

\_\_\_\_\_  
 City, State Zip

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Phone or email

Once WFSM Whole Body Donation Program receives the body there will be no opportunity for family or friends to view the body. Such arrangements should be made prior to release. Also, no autopsy will be performed; therefore, no study of cause of death or related disease information can be reported to the family.

**Funeral Home or Transportation Service Provider**

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Phone Number