

WILLED BODY DONATION PROGRAM POLICY

The donation of a person's body after death is a tremendous gift. The Southeast Texas Applied Forensic Science (STAFS) facility of Sam Houston State University is grateful for everyone who expresses an interest in body donation.

Please read the following policies of STAFS and sign and date below. **Please note that all original documents of the required paperwork, as well as a copy of the donor's valid photo ID, must be received by STAFS before the file is complete. Original documents must be received within 60 days of date on the Living Donor Letter received with packet, or paperwork could be considered outdated.**

1. Unlike some medical schools, **STAFS does not return remains to the family.** The skeletal remains are a very important component of our anatomical collection used for forensic research, teaching, and training programs.
2. Each donation is carefully considered on a case-by-case basis. **STAFS reserves the right to decline donations if the Willied Body Program is unable to use the donor's body for any reason.** STAFS always suggests that donors have an alternative plan in the event of donation denial.
3. **STAFS will arrange transportation to our facility if the deceased is located within the state of Texas and within 200 miles of Huntsville.** Outside of Texas or more than 200 miles from Huntsville, the donor or donor's family must arrange for the transportation of the body and must assume responsibility for any costs associated with such transportation.
4. **STAFS cannot transport a donor from a private residence.** STAFS may transport a body from a hospital, funeral home, forensic center, or some healthcare facilities that are within the 200 mile in-state geographic limits as noted above in Paragraph 3. The donor's family must arrange for transportation from a private residence in addition to temporary storage if required. The family must assume responsibility for these costs.
5. **Signed donation documents and/or releases must be executed prior to transportation of the donated body to STAFS.** These documents may be emailed or faxed to STAFS, but the original documents and/or releases must be postmarked to STAFS within three (3) business days following receipt of the emailed and/or faxed copies. Your donation paperwork will not be considered complete until original documents with all required signatures are received by STAFS.
6. All donor questionnaire information and signed paperwork/releases must be completed and returned to STAFS for a file to be established. Any change of address or medical status must be promptly provided to STAFS to keep donor files up to date.
7. **All donor paperwork requires identification information and original signatures of two (2) witnesses to verify the donor's, next of kin's, or executor's signature.** Texas law requires two (2) witnesses' signatures **but does not require notarization.**
8. All identifiable information provided on the Body Donation Questionnaire and any related documents will be kept confidential, unless required by law or court order.
9. STAFS reserves the right to decline the donation of individuals who weigh over 300 pounds.

10. Complaints or inquiries regarding a willed or donated body should be directed to the Texas Funeral Service Commission. The name and address of this individual may be obtained from the institution to which the body was delivered.
11. **If you have any questions or concerns that have not been addressed in this policy letter, please feel free to contact STAFS at 936-294-2310 or stafs@shsu.edu.**

I have read, understand, and agree to the policy of STAFS' Willed Body Donation Program.

Printed Name of Living Donor

Signature of Living Donor

Date

Living Donor Mailing Address

Living Donor Phone Number

Living Donor Email

Witnesses to the signature of the Living Donor Please Sign Below

Printed Name of 1st Witness

Signature of 1st Witness

Date

1st Witness Mailing Address

1st Witness Phone Number

1st Witness Email

Printed Name of 2nd Witness

Signature of 2nd Witness

Date

2nd Witness Mailing Address

2nd Witness Phone Number

2nd Witness Email

LIVING DONOR RELEASE FORM

I, _____, do hereby dispose of and give my body, after my death, to Sam Houston State University, for the use by STAFS, or its designee, for all forensic or medically related educational and research purposes, whether within or without the State of Texas. I request, authorize, and instruct my surviving spouse, next of kin, executor, or the physician who certifies my death to notify STAFS at Sam Houston State University (telephone: 936-294-2310) immediately after my death of the availability of my body.

The Willed Body Program at Sam Houston State University is recognized by the Texas Funeral Service Commission. It is my wish that at the time of my death my body be made available for all forensic and/or medically related educational and research purposes, including teaching and scientific purposes, to Sam Houston State University and that it will not be returned to my next of kin or any other recipient. I understand that the University will pay for transportation of my body if it is located within a 200-mile radius of Sam Houston State University, Huntsville, Texas 77340 and is within the State of Texas.

I understand that STAFS at Sam Houston State University reserves the right to decline donations. If the Willed Body Program is unable to use my body for any reason, my next of kin is responsible for making other final disposition arrangements. The Willed Body Program is not responsible for any costs associated with other necessary arrangements. I understand and acknowledge that STAFS at Sam Houston State University does not return remains to families.

I consent to this anatomical donation its use for all educational and research purposes, including forensic and medical science, whether within or without the State of Texas. At the time of my death, I hereby relinquish all rights and claims regarding my body and direct that by accepting and using my body for teaching and scientific purposes and its subsequent disposition, Sam Houston State University (SHSU) shall not be liable for any claim that may arise against SHSU with regard to my donation.

I understand and acknowledge that biological sampling and genetic testing may be necessary to ensure the proper handling and care of willed or donated bodies and hereby consent to such sampling and testing and further understand and acknowledge that all genetic information will remain confidential and will not be disclosed to others unless required by law or court order.

(CONTINUE TO NEXT PAGE)

LIVING DONOR RELEASE FORM CONTINUED

I have read, understand, and agree to the STAFS Living Donor Release Form..

Printed Name of Living Donor

Signature of Living Donor

Date

Living Donor Mailing Address

Living Donor Phone Number

Living Donor Email

Witnesses to the signature of the Living Donor Please Sign Below

Printed Name of 1st Witness

Signature of 1st Witness

Date

1st Witness Mailing Address

1st Witness Phone Number

1st Witness Email

Printed Name of 2nd Witness

Signature of 2nd Witness

Date

2nd Witness Mailing Address

2nd Witness Phone Number

2nd Witness Email

Specific Research Programs

Please indicate your consent for the specific research programs below by **placing your initials next to appropriate statement:**

TRAUMA RESEARCH

The STAFS Facility engages in a wide variety of research that benefits forensic science. Some of this research investigates the bio mechanics of trauma inflicted upon the body, as well as how that trauma may affect sciences such as DNA, chemistry, biology, anatomy, anthropology, and entomology. This allows us to better understand skeletal conditions that are presented in forensic cases. In addition, this research helps increase our knowledge of the mechanisms of trauma so more effective equipment can be designed to protect first responders and military personnel.

Please note that this trauma can include the following: 1. **Blunt Force Trauma (BFT)**- studies that evaluate how impacts by blunt instruments (i.e. bat, hammer), car accidents, and/or falls affect the body and/or collection of evidence from the body. 2. **Sharp Force Trauma (SFT)**- studies that evaluate how marks and fractures left behind by sharp instruments, such as knives or saws, affect the body and/or collection of evidence from the body. 3. **Projectile Trauma**- studies that examine how high velocity trauma, such as gunshots or blasts, affect the body and/or the collection of evidence from the body. 4. **Thermal Trauma**- studies that examine the damage that occurs to the body and/or evidence collected from the body during and/or after the exposure of high temperatures, such as fires or cremation.

_____ **YES**, I permit the remains to be used in research that involves the simulation of violent crimes to advance the fields of anthropology, death investigation practices, and medicolegal research. I fully understand that by permitting this research, I am consenting to research that may result in trauma to the remains, as described above.

_____ **NO**, I do not permit the remains to be used in research that involves the simulation of violent crimes to advance the fields of anthropology, death investigation practices, and medicolegal research.

(CONTINUE TO NEXT PAGE)

GENEALOGY RESEARCH

*Please indicate your consent for the specific research programs below by **placing your initials next to appropriate statement:***

The STAFS Facility takes careful measures to protect the privacy of our donors and their families. Human genome sequencing (DNA) research is very important in forensic science to improve the identification process of unknown individuals in forensic casework, cold cases, and missing persons cases. However, some kinship-based methods also have the potential to identify biologically related family members. Please note that all DNA studies involving living individuals must also be reviewed by the SHSU Institutional Review Board, and identifiable or personal information (such as name, contact details, date of birth, social security, etc) will remain confidential.

_____ **YES**, I do permit the remains to be used in research that involves genealogy and understand that I may be contacted in the future for possible further reference samples from myself and/or any living biologically related individual(s) willing to participate. I fully understand that by permitting this research, I am consenting to research that could define genetic links with biologically related individuals. **I understand that this research may consist of comparing unidentifiable material to external or public databases, however no genetic or personal identifiable information will be housed on any public DNA databases.**

_____ **NO**, I do not permit the remains to be used in research that involves genealogy.

POTENTIALLY IDENTIFIABLE RESEARCH

*Please indicate your consent for the specific research programs below by **placing your initials next to appropriate statement:***

The use of images, videos, scans, radiographs, casts, 3D prints, and/or other representations of human remains that currently exist or are developed in the future are highly valuable for education and research purposes. These representations are important in perfecting identification techniques such as facial reconstruction and understanding body mechanics and disease progression. However, these images have the potential to include identifiable information about the person (e.g. the face, tattoos, birthmarks, etc.). These images may be used in educational and research presentations and in publications. Please note that all research projects, presentations, and publications involving imagery must be approved by the Director of STAFS.

_____ **YES**, I permit the remains to be used for research, presentations, and publications using potentially identifiable imagery.

_____ **NO**, I do not permit the remains to be used for research, presentations, and publications using potentially identifiable imagery.

(CONTINUE TO NEXT PAGE)

Specific Research Programs (Continued)

I hereby confirm that I have indicated my preference for each of the above listed specific research programs by placing my initials next to the appropriate responses.

Printed Name of Living Donor

Signature of Living Donor

Date

Living Donor Mailing Address

Living Donor Phone Number

Living Donor Email

Witnesses to the signature of the Living Donor Please Sign Below

Printed Name of 1st Witness

Signature of 1st Witness

Date

1st Witness Mailing Address

1st Witness Phone Number

1st Witness Email

Printed Name of 2nd Witness

Signature of 2nd Witness

Date

2nd Witness Mailing Address

2nd Witness Phone Number

2nd Witness Email

Living Donor Information

Please complete this questionnaire to the best of your ability. Please note that this information is in regards to the yourself, as the Living Donor. If you need more space, additional sheets may be attached. If the answer is unknown please mark "UNK" for the answer. If the answer is not applicable, please mark "N/A". **Please do not leave any sections blank.**

***** The information marked by an asterisk (*) is required to complete the Death Certificate. The STAFS Facility will file a Death Certificate for all donors unless otherwise specified.**

*Name: _____ / _____ / _____ / _____
First Middle Last Maiden/Suffix

*Date of Birth: ____/____/____ *Place of Birth (City, State, County): _____

*Biological Sex: Male Female Intersex *Social Security #: _____

*Home Address: _____ *Apt/Unit #: _____

*City: _____ *State: _____ *Zip: _____ *County: _____

*Is this residence within city limits? Yes No

*Current Marital Status (select one): Never Married Married Widowed and not Remarried Divorced

*Spouse's Name: _____ / _____ / _____ / _____
First Middle Last Maiden/Suffix

Mother's Current Status (select one): Living Deceased Unknown

*Mother's Name _____ / _____ / _____ / _____
First Middle Last Maiden/Suffix

Father's Current Status (select one): Living Deceased Unknown

*Father's Name _____ / _____ / _____ / _____
First Middle Last Maiden/Suffix

*Texas Peace Officer? Yes No Unk

*Military Service? Yes No Unk

*IF YES, Military Branch & Serial #: _____

***Highest Education Level**

<input type="checkbox"/> Unknown	<input type="checkbox"/> Associate Degree (AA, AS)
<input type="checkbox"/> 8 th Grade or Less	<input type="checkbox"/> Bachelor's Degree (BA, AB, BS)
<input type="checkbox"/> 9 th -12 th Grade	<input type="checkbox"/> Master's Degree (MA, MS, MENG, MED, MSW, MBA)
<input type="checkbox"/> HS Graduate or GED Completed	<input type="checkbox"/> Doctorate (PhD, EDD)
<input type="checkbox"/> Some College Credit, but not a degree	<input type="checkbox"/> Professional (MD, DDS, DVM, LLB, JD)

*Race (select all that apply)		*Hispanic Origin? (select one)
<input type="checkbox"/> White	<input type="checkbox"/> Japanese	<input type="checkbox"/> No
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Korean	<input type="checkbox"/> Yes, Mexican
<input type="checkbox"/> American Indian/Alaskan Native Tribe (Specify): _____	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Yes, Mexican American or Chicano
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Yes, Puerto Rican
<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian/Chamorro	<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan	<input type="checkbox"/> Unknown
Other (Specify): _____		<input type="checkbox"/> Other (Specify): _____

Ancestry: _____
(i.e. Irish, Israeli, Ugandan, etc)

Is your ancestry from a DNA company (e.g. Ancestry.com)? Yes No

If you would like to submit your results to STAFS, please attach a copy to this form or email to stafs@shsu.edu

***Occupation (life-long):** _____ ***Business/Industry:** _____

Please note the state requires an Occupation and Business/Industry listed for the death certificate. If you have never been employed at any point during life, list "None" for Occupation and an explanation as to why in Business/Industry. If you are taking care of home or dependents, "Homemaker" can be listed.

Occupational History: Please describe your job history, how many years you worked in that position/field and the year of retirement if applicable. Please attach additional sheets if necessary.

Job Title/Field	Number of Years	Year of Retirement	Manual Labor? Yes or No

Geographic History- First 15 Years: *Geographic location where you spent the first 15 years of your life. If the information is unknown, please write "Unknown". Please be as detailed as possible. If you need more space, please attach the information in the same format.*

Address	City	State	Zip Code	Start Age	End Age

Geographic History- Last 20 Years: *Geographic location where you spent the last 20 years of your life. If the information is unknown, please write "Unknown". Please be as detailed as possible. If you need more space, please attach the information in the same format.*

Address	City	State	Zip Code	Start Age	End Age

Childhood Socio-Economic Status: Lower Lower Middle Middle Upper Middle Upper Unknown

Current Socio-Economic Status: Lower Lower Middle Middle Upper Middle Upper Unknown

Height: _____ (Is this estimated? Yes No) **Weight:** _____ (Is this estimated? Yes No)

Dramatic weight change during lifetime? Yes No Unk **Are you considered obese?** Yes No Unk

Handedness: Right Left Ambidextrous Unk **Blood Type:** A B AB O Unk
If A or B Blood Type: Positive Negative Unk

Eye Color: Brown Blue Green Hazel Gray Unk Other: _____

Natural Hair Color: Brown Shades Blonde Shades Red/Auburn Shades Black Unk

Other: _____

Tattoos: Yes No Unk *If Yes, Describe:* _____

Body Piercings: Yes No Unk *If Yes, Describe:* _____

Exercise: None Sedentary Moderate Vigorous Cardio Weights Unk

Specify type/frequency of workouts: _____

If Sedentary, how many years? _____

Mobility: Do you have mobility restrictions? Yes No Unk

If Yes, what type of restrictions and how many years? _____

Habitual Activities: List any habitual activities the you have participated in, including occupational stressors that may have affected your body. If the information is unknown, please write "Unknown".

Tobacco Use: Never Former Active Unk

If Former or Active, specify Type: Chewing Cigar/Pipe Cigarettes Unk

If Former or Active, specify amount: _____ per Day Week Year Unk

If Former or Active, specify number of years/age(s): _____

Alcohol Use: Never Former Active Unk

If Former or Current, specify Type: Beer Wine Liquor Unk

If Former or Current, specify amount: _____ per Day Week Year Unk

If Former or Current, specify number of years/age(s): _____

Recreational Drug Use: Never Former Active Unk

If Former or Active, type(s): _____

Dental Information: Do you have most/all teeth? Yes No Unk Any teeth missing? Yes No Unk

Have you ever had braces? Yes No Unk Do you have a bridge? Yes No Unk

Do you have dentures? Yes No Unk Do you have a history of gum disease? Yes No Unk

If you marked "yes" to teeth missing, braces, bridge, dentures, and/or history of gum disease, please indicate what age the you were, as well as specific information on location (i.e. braces from age 13-16, upper dentures at age 65, etc)

Medical History: Please describe in as much detail as possible your medical history. **Please note condition type, year(s) of onset, location, and/or any other additional information when appropriate.** Please attach additional sheets if necessary.

Condition	Specify type, year(s) of onset, location, and/or any other additional information
MRSA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Prion Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Sexually Transmitted Infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
HIV/AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Chemotherapy/Radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Other Joint Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

<p>Amputations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Traumatic Brain Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Alzheimer's/Dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Gout? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Osteopenia/Osteoporosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Stroke/TIA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Seizure Disorder/Epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Cardiovascular Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Eating Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>COPD/Emphysema? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Depression? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Other Mental Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Thyroid Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	
<p>Any history of fractured bones? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <i>If yes, specify age, location, and how it was fractured</i></p>	

Additional Medical History: Please describe in as much detail as possible any other medical history that was not documented above, or that you would like to expand upon such as: hospital admittance prior to passing, general medical history, and/or any other information. Please attach additional sheets if necessary.

CHILDREN INFORMATION

Number of Pregnancies (if any): _____ Number of Miscarriages (if any): _____

List below information regarding any biological and/or legal children that you may have. Please add additional sheets if needed.

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

SIBLING INFORMATION

List below information regarding any biological and/or legal siblings that you may have. Please add additional sheets if needed.

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

Name: _____ Current Status: Living Deceased Unknown

Age: _____ Phone #: _____ Email: _____

Address: _____

Biological Adoptive Step

ADDITIONAL RESEARCH REQUESTS

If you have any specific concerns regarding the use of remains for teaching and research purposes at STAFS, or if you have any research use preferences, please explain below. Please also note any religious requirements you may have that could affect research being conducted (for example, cannot be cremated, etc). STAFS makes every effort to accommodate specific research requests, however accommodation is not guaranteed.

DONATION PAPERWORK CHECK LIST

- ___ **STAFS Release Forms, Specific Research Consents** (*Pages 2-7*)
- ___ **Living Donor Information** (*Pages 8-17*)
- ___ **Copy of Living Donor ID**
- ___ **Photographs-** Photographs may be used to help develop better methods of facial reconstruction for unidentified individuals. Please include the photographs listed below if available and desired.
 - Two (2) different close-up facial photographs with a neutral expression
 - One (1) profile (side view) photograph with a neutral expression
 - Various photographs (copies) from childhood

PLEASE EMAIL A COPY OF THIS COMPLETED PACKET, ALONG WITH ALL OTHER SUPPORTING DOCUMENTS SUCH AS PHOTO ID, TO STAFS@SHSU.EDU FOR REVIEW.

Any questions or concerns regarding this donation packet should be directed at the following contact information:

STAFS Facility

Phone Number: 936-294-2310

Email: stafs@shsu.edu

Website: <https://ifrti.org/STAFS/>

STAFS Facility Business Hours: Monday-Friday, 8am to 5pm CST***

Please wait to mail the original documents until you receive confirmation that STAFS has a completed electronic copy.

Return completed original forms to the following address:

Southeast Texas Applied Forensic Science Facility (STAFS)
Sam Houston State University
Box 2529
Huntsville, TX 77341

****All University holidays, as well as KatSafe campus closures, are observed by the STAFS Facility.*

For more information on the SHSU Holiday Schedule, please visit:

https://www.shsu.edu/dept/hr/benefits/holidays.html?utm_source=later-linkinbio&utm_medium=referral&utm_campaign=linkinbio#holidays.

For more information on KatSafe campus closures, please visit:

https://www.shsu.edu/katsafe/?utm_source=later-linkinbio&utm_medium=referral&utm_campaign=linkinbio

INSTRUCTIONS FOR OBTAINING THE DEATH CERTIFICATE

The STAFS Facility does not issue the death certificate, nor does it order any copies. Once released to the state, death certificates are obtained through the County Clerk's Office in the county of the deceased's residence. Under Texas law, a death certificate must be initiated within 10 days from the date of death.

STEPS IN THE DEATH CERTIFICATE PROCESS

1. Once the donor is transported to and received by STAFS, STAFS will begin working on the death certificate by entering the donor's information into the state's electronic database.
 - a. Please note that STAFS cannot begin working on a death certificate until the transportation process is complete and the donor is at the STAFS Facility. Because of this, initiation of the death certificate may have to be started by the releasing agency but will be finished by the STAFS Facility unless otherwise arranged with the family.
2. This information is electronically sent to the certifying physician/medical examiner, who then completes the portion concerning cause and manner of death.
3. The death certificate is then returned to STAFS to verify that all information is correct. STAFS will send the Verification of Death Facts form to the informant listed on the donation paperwork for review and approval.
4. Once the Verification of Death Facts form is reviewed, approved, and signed by the informant, the death certificate is released in state's electronic database to the local registrar. In most cases, the local registrar is the County Clerk's Office.
5. The donor's death certificate is then available to the family/next of kin/informant. Under normal circumstances, this entire process takes approximately two (2) weeks.
6. The death certificate can be obtained from the county clerk's office in the county where the donor passed away **OR** requested online at the Texas Vital Statistics website: <https://www.dshs.texas.gov/vital-statistics/death-records>.

Appointment for Disposition of Remains

I, _____ (your name and address) being of sound mind, willfully and voluntarily make known my desire that, upon my death, the disposition of my remains shall be controlled by _____ (name of agent) in accordance with Sections 692A.009 of the Health and Safety Code, and with respect to that subject only, I hereby appoint such person as my agent (attorney-in-fact).

All decisions made by my agent in order to carry out the disposition of my remains as an anatomical gift pursuant to 692A.009 shall be binding.

SPECIAL DIRECTIONS:

Set forth below are any special directions limiting the power granted to my agent:

AGENT:

Name:

Address:

Telephone:

SUCCESSORS:

If my agent or a successor agent dies, becomes legally disabled, resigns, or refuses to act, or if I divorce my agent or successor agent and this instrument does not state that the divorced agent or successor agent continues to serve after my divorce from that agent or successor agent, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent (attorney-in-fact) to control the disposition of my remains as authorized by this document:

1. First Successor

Name:

Address:

Telephone Number:

Agent Initials _____

Donor Initials _____

2. Second Successor

Name: _____

Address: _____

Telephone Number: _____

DURATION:

This appointment becomes effective upon my death.

PRIOR APPOINTMENTS REVOKED:

I hereby revoke any prior appointment of any person to control the disposition of my remains.

RELIANCE:

I hereby agree that any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document may act under it. Any modification or revocation of this document is not effective as to any such party until that party receives actual notice of the modification or revocation. No such party shall be liable because of reliance on a copy of this document.

ASSUMPTION:

THE AGENT, AND EACH SUCCESSOR AGENT, BY ACCEPTING THIS APPOINTMENT, ASSUMES THE OBLIGATIONS PROVIDED IN, AND IS BOUND BY THE PROVISIONS OF, SECTION 692A.009 OF THE HEALTH AND SAFETY CODE.

SIGNATURES:

This written instrument and my appointments of an agent and any successor agent in this instrument are valid without the signature of my agent and my successor agents below. Each agent, or a successor agent, acting pursuant to this appointment must indicate acceptance of the appointment by signing below before acting as my agent.

Signed this _____ day of _____, 20__.

_____ (your signature)

State of _____

County of _____

Agent Initials _____

Donor Initials _____

This document was acknowledged before me on _____ (date) by
_____ (name of principal).

_____ (signature of notarial officer)

(Seal, if any, of notary)

_____ (printed name)

My commission expires: _____

ACCEPTANCE AND ASSUMPTION BY AGENT:

I have no knowledge of or any reason to believe this Appointment for Disposition of Remains has been revoked.
I hereby accept the appointment made in this instrument.

Acceptance of Appointment:

_____ (signature of agent)

Date of Signature: _____

Acceptance of Appointment:

_____ (signature of first successor)

Date of Signature: _____

Acceptance of Appointment:

_____ (signature of second successor)

Date of Signature: _____

Authorization to Disclose/Release Confidential Donor and Donation Information

On this _____ day of _____, in the year of 20_____

I, _____
(Principal Signer PRINT First Name and Last Name) (Signature of Principal Signer)

Hereby authorize the following list of adult individuals below to receive confidential donor and donation information pertaining to:

(For Living Donation Applicants-list your First and Last Name again, For Next-of-Kin Applicants-list First and Last Name of Deceased)

Limitations of this authorization include modifications or alterations to original donation application(s) and original donation paperwork.

**List of Authorized Adult Individuals Eligible to Receive Confidential Donor and Donation Information:
*Each Adult Individual Must Provide Proof of Photo ID to be Considered Eligible***

Printed Full Name _____ Signature _____
Phone # _____ Email _____
Mailing Address _____
Relationship to donor/applicant _____

Printed Full Name _____ Signature _____
Phone # _____ Email _____
Mailing Address _____
Relationship to donor/applicant _____

Printed Full Name _____ Signature _____
Phone # _____ Email _____
Mailing Address _____
Relationship to donor/applicant _____

Printed Full Name _____ Signature _____
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Mailing Address _____
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Printed Full Name _____ Signature _____
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