

**AFTER MY DEATH, DONATION OF ORGANS OR BODY**  
(THIS FORM IS OPTIONAL. FILL OUT ONLY WHAT REFLECTS YOUR WISHES.)

BY: \_\_\_\_\_  
(PRINT NAME)

DATE OF BIRTH: \_\_\_\_\_  
(MONTH/DAY/YEAR)

**PART I: ORGAN DONATION**

(INITIAL THE ONES THAT YOU WANT.)

UPON MY DEATH I WISH TO DONATE:

ANY NEEDED ORGANS, TISSUES, OR EYES. \_\_\_\_\_

ONLY THE FOLLOWING ORGANS, TISSUES, OR EYES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I AUTHORIZE THE USE OF MY ORGANS, TISSUES, OR EYES:

FOR TRANSPLANTATION \_\_\_\_\_

FOR THERAPY \_\_\_\_\_

FOR RESEARCH \_\_\_\_\_

FOR MEDICAL EDUCATION \_\_\_\_\_

FOR ANY PURPOSE AUTHORIZED BY LAW \_\_\_\_\_

I UNDERSTAND THAT NO VITAL ORGAN, TISSUE, OR EYE MAY BE REMOVED FOR TRANSPLANTATION UNTIL AFTER I HAVE BEEN PRONOUNCED DEAD UNDER LEGAL STANDARDS. THIS DOCUMENT IS NOT INTENDED TO CHANGE ANYTHING ABOUT MY HEALTH CARE WHILE I AM STILL ALIVE. AFTER DEATH, I AUTHORIZE ANY APPROPRIATE SUPPORT MEASURES TO MAINTAIN THE VIABILITY FOR TRANSPLANTATION OF MY ORGANS, TISSUES, AND EYES UNTIL ORGAN, TISSUE, AND EYE RECOVERY HAS BEEN COMPLETED. I UNDERSTAND THAT MY ESTATE WILL NOT BE CHARGED FOR ANY COSTS RELATED TO THIS DONATION.

**PART II: DONATION OF BODY**

AFTER ANY ORGAN DONATION INDICATED IN PART I, I WISH MY BODY TO BE DONATED FOR USE IN A MEDICAL STUDY PROGRAM.

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**PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS**

**I WANT THE FOLLOWING PERSON TO MAKE DECISIONS ABOUT THE DISPOSITION OF**