

Check One: New
 Update

MUSC ANATOMICAL GIFT PROGRAM - DONOR INFORMATION

Please complete the information requested below and return to the
MUSC Anatomical Gift Program. It is required in order to complete your death certificate.
PLEASE PRINT LEGIBLY OR TYPE ENTIRE FORM.

Name: _____ SSN: _____ - _____ - _____
Last First Middle

Mailing Address: _____

Street Address: _____ Inside City Limits: Yes
Street and Number if Different from Mailing Address No

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

Home Phone: () - _____ Date of Birth (mm/dd/yyyy): ____/____/____

State and City of Birth: _____ Citizen of What Country: _____
(if not USA, name country)

Race: Caucasian Sex: Male Marital Status: Married
 Black Female Never married
 Hispanic _____ Widowed
(specify Cuban, Mexican, Puerto Rican, etc.) Divorced
 American Indian Separated
 Oriental
 Other _____ Served in Armed Forces: Yes
(specify) No

Education: Elementary: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 5+
(Circle number of highest level of education completed)

Usual Occupation: _____ Business/Industry: _____
(Type done during most of working life, even if retired) (Indicate type of business/industry of occupation)

Spouse's Name (if wife give maiden name) _____
Last First Middle

Father's Name: _____
Last First Middle

Mother's Maiden Name: _____
Last First Middle

Next of Kin Name: _____ Relationship: _____
(Specify spouse, son, daughter, etc.)

Address: _____ City: _____ State: _____ Zip: _____
Street and Number

Home Phone: () - _____ Alternate Phone: () - _____

E-mail Address: _____

Signature: _____ Date: _____
(To my knowledge the above information is true and correct)

Yes, my cremated remains are to be returned to my Next of Kin.