

THIS FORM IS SUPPLIED FOR THE CONVENIENCE OF DONORS AND IS IN NO WAY LEGALLY BINDING IF THE DONORS OR THEIR RELATIVES AT ANY TIME WISH TO ALTER OR REVOKE ANY PART THEREOF.

Please return the original copy of this form in the reply paid envelope enclosed, or:

Human Bequest Coordinator Discipline of Anatomy College of Medicine and Dentistry James Cook University Townsville QLD 4811

PLEASE PRINT ALL INFORMAT		Consent F	orm		
Surname: (Mr/Mrs/Miss/Ms/	'Dr)				
Given Names:					
Home Address:					
Postal Address:					
Email:					_
Date of Birth:/					-
Telephone: Home:			Mobile:		
Are you of Aboriginal or Torres S	trait islander origin?	□ Yes	□ No	□ Prefer not to	say
It is my wish that my remains, afte University to be used in whatsoe or in the study, research, and tea	ver way may be deem	ned most ben	eficial for the pu		
I consent to my remains being retick one box only):	etained indefinitely. I u	nderstand tha	at I will be crema	ated and my ashes v	vill be (please
☐ Scattered at the memo	orial garden at Woong	arra Cremato	rium, or		
☐ Returned to the next of memorial garden at Woo		t my NOK is ι	ıncontactable, m	ny ashes are to be so	attered at the
I have discussed this decision w University to accept my offer.	rith my next of kin. I u	understand th	at circumstance	es may make it impo	ssible for the



WITNESSES

Please ensure that your signature is witnessed by TWO people.

Witness 1:		
Signed:	Date:	
Full Name:		
Witness 2:		
Signed:	Date:	
Full Name:		
Address:		
Current medical conditions:	MEDICAL HISTORY	
Previous surgeries and medic	cal conditions:	



Next of Kin

The next of kin is responsible for contacting the Human Bequest Coordinator at the time of death. We recommend they be a spouse, relative, friend, neighbour etc. Generally, a solicitor or Public Trustee is not suitable as they are unlikely to notify JCU in a reasonable time.

I/We the undersigned SENIOR NEXT OF KIN of the above, have NO objection to his/her wishes as stated above. I have read through the Information form and understand how the Body Donation Program works. I am aware that circumstances may make it impossible for the University to accept the donation at time of death and I acknowledge that alternative arrangements may need to be made by the Donor's family.

1. Name: (Mr/Mrs/Miss/Ms/Dr)			
1. Name: (Mr/Mrs/Miss/Ms/Dr) _	Surname	Given Names	•
Home Address:			
Postal Address:			
Email:			-
		Mobile:	
Signed:	Relationship to Donor:		
2. Name: (Mr/Mrs/Miss/Ms/Dr) _	Surname	Given Names	-
Home Address:			
Postal Address:			
Email:			-
Telephone: Home:	Work:	Mobile:	
Signed:	Relationship to Donor:		
5 5	ogether with mer	tives of those who have donated their labers of the University staff and health tick one box only):	
☐ I wish to be notified of t☐ I do not wish to be noti		anksgiving Service sity Thanksgiving Service	



College of Medicine & Dentistry
Telephone (07) 4781 5022
International +61 7 4781 5022
Email: humanbequest.coordinator@jcu.edu.au

AUTHORITY TO RELEASE

l,of:	
(NOK Name)	(NOK Address)
(Address co	ontinued)
Being the senior available next of kin, authorise 1. Consent for the release of medical information screening process	_
2. Funeral Transfer Service nominated by Jam	nes Cook University collection and transfer of:
The late	
(name of Decea	ased Donor)
From:	
(to be complete	ed at time of death)
To: Discipline of Anatomy, College of Medicine &	Dentistry, James Cook University, Townsville.
NOK Signed:	
NOK Print Name:	
NOK Relationship to Deceased:	

Please have your next of kin (NOK) complete this 'Authority to Release' form (leaving the 'from' section BLANK). We require this form to be on file with the consent form at the time of registration as this is often difficult for the next of kin to complete at the time of the donor's passing, and is required for transfer.