



**BEQUEST (DONOR) FORM**

**THE WILLED BODY PROGRAM**

Baylor College of Medicine  
One Baylor Plaza, BCM130  
Houston, Texas 77030  
Phone (713) 798-3858

It is my wish that subsequent to my death, Baylor College of Medicine, as a representative of the Anatomical Board of the State of Texas, receives my body for teaching and scientific purposes. To assure that maximum benefit is derived from the contribution, I authorize Baylor College of Medicine to transfer my body to other teaching or research institutions within the State of Texas if the needs of such institutions are deemed appropriate. Such transfer will be made at the discretion of Baylor College of Medicine.

Furthermore, I authorize the Anatomical Board of the State of Texas to transport the willed/donated body hereon described out of the State of Texas in the event that the holding institution and the executive secretary of that board have determined that an excess of bodies currently exists in the State of Texas.

( ) Yes ( ) No \_\_\_\_\_  
(Initials) (Date)

Complaints or inquires regarding a willed or donated body should be directed to the executive secretary of the Anatomical Board of the State of Texas. The name and address of this individual may be obtained from the institution to which the body was delivered and is listed in the Texas State Telephone Directory.

It is my understanding that if an autopsy is necessary, or other extenuating circumstances occur, such as, traumatic injury, contagious disease (HIV virus, hepatitis), suicide, or if organs or parts have been removed for transplantation or otherwise, my body may not be accepted to the willed body program.

\_\_\_\_\_  
Name of DONOR (Please Print) Birth date: Social Security #:

\_\_\_\_\_  
Address of DONOR including City, State and Zip Code

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of DONOR

\_\_\_\_\_  
Name of Next of Kin (Please Print) Relationship to Donor

\_\_\_\_\_  
Address of Next of Kin including City, State and Zip Code

\_\_\_\_\_  
Phone number of Next of Kin Email address of Next of Kin

**Signature and addresses of two witnesses, preferably anticipated survivors:**

We the undersigned witnesses, certify that we were over the age of 21 years at the time of the donor's signature and that we witnessed such signature.

\_\_\_\_\_  
Name of Witness (Please Print)

\_\_\_\_\_  
Name of Witness (Please Print)

\_\_\_\_\_  
Address of Witness

\_\_\_\_\_  
Address of Witness

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
City, State and Zip Code

Signed: \_\_\_\_\_  
Signature of Witness Date:

Signed: \_\_\_\_\_  
Signature of Witness Date:

**Return signed original to address above; Keep copies for your files.**