

UCLA Donated Body Program

Donor's Legal Name _____

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UCLA Donated Body Program

University of California Los Angeles
David Geffen School of Medicine at UCLA
PO BOX 957340, Los Angeles, CA 90095-7340



All donor registration forms must be completed and signed where indicated. The UC Donation Agreement will require a signature witnessed by two people or a Notary Public. Mail the completed forms, which include the entire donor application, to the UCLA Donated Body Program in the envelope provided or to the address noted above. Once the forms have been reviewed and accepted by the Program, an acknowledgement will be sent to you along with a donor identification card. Please feel welcome to call the UCLA Donated Body Program at 310-794-0372 for questions or assistance in completing the forms. All information provided will remain confidential to the extent allowed by law.

Vital Statistics

The information provided is of great value to teaching and research and is also required to complete certain government forms. The information will also be used for completion and processing the **death certificate** with the State of California, Office of Vital Records. All boxes must be completed to the best of your ability. If you do not have the information for an item, write "unknown" or "none" in that space. Do not leave any blank boxes. Please PRINT all information and double check for spelling errors.

Worksheet for Education and Race/Ethnicity

This form is a guide when completing certain items found on the Vital Statistics form.

Donation Agreement

Please sign this form in front of two witnesses or a Notary Public (if you are signing the donation agreement for yourself). If the donation is made by the authorized agent under a valid durable power of attorney for healthcare or directive that expressly authorizes the authorized agent to make an anatomical gift of all or part of the principal's body, **a complete legible copy of the durable power of attorney for health care or directive must accompany this form.**

Order for Release

Please sign where indicated. This form is used only when a signed release is required from a hospital or other institution.

Note: Specific pages of the donation agreement may or may not apply depending on whether you are donating for yourself or if the donation agreement is being completed on behalf of another person. Feel free to contact us at 310-794-0372 for any questions.



University of California Los Angeles
 David Geffen School of Medicine at UCLA Donated Body Program
 PO Box 957340, Los Angeles, CA 90095-7340 • 310-794-0372 FAX 310-794-0334

PLEASE PRINT LEGIBLY-THIS INFORMATION IS USED TO COMPLETE THE DEATH CERTIFICATE

DONOR NAME: _____ MALE FEMALE

AKA: _____ FIRST _____ MIDDLE _____ LAST _____ PHONE _____ DATE: _____

USUAL ADDRESS: _____ STREET _____ CITY _____ STATE/ZIP CODE _____

COUNTY OF RESIDENCE: _____ No. OF YEARS IN THIS COUNTY: _____

RACE/ETHNICITY: _____ SPANISH/HISPANIC: Yes No Specify _____
 (PLEASE COMPLETE THE ATTACHED EDUCATION AND RACE IDENTITY WORKSHEET)

DATE OF BIRTH: _____ STATE OF BIRTH _____ or FOREIGN COUNTRY: _____

FULL NAME OF FATHER _____ BIRTHPLACE OF FATHER: _____
 First Middle Last

FULL MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER: _____
 First Middle Last

SOCIAL SECURITY #: _____ - _____ - _____ US ARMED FORCES: Yes No Unknown

MARITAL STATUS: NEVER MARRIED, MARRIED, WIDOWED, DIVORCED, REGISTERED DOMESTIC PARTNER

NAME OF SURVIVING SPOUSE (If wife, enter MAIDEN name): _____
 First Middle Last

USUAL OCCUPATION: _____ YEARS IN OCCUPATION: _____
 (If you are now retired, please give occupation information BEFORE retirement)

KIND OF INDUSTRY OR BUSINESS: _____

EDUCATION (highest level/degree completed - see worksheet): _____

NAME OF PHYSICIAN _____ PHONE No. _____

HEIGHT _____ WEIGHT _____ PRESENT STATE OF HEALTH _____

SURGICAL HISTORY: KNEE, HIP, SHOULDER, SPINE OR OTHER JOINT? _____

HYSTERECTOMY? Yes No PROSTATECTOMY? Yes No

DISEASE HISTORY or TREATMENT: HEPATITIS A, B OR C, HIV/AIDS, TUBERCULOSIS, OTHERS (MRSA, CREUTZFELDT-JAKOB)? _____

ADDITIONAL HEALTH INFORMATION INCLUDING ILLNESSES, OPERATIONS, ACCIDENTS: _____

HOW DID YOU HEAR OF THE PROGRAM: Friend Program Website Facebook/Instagram/YouTube Newspaper
 UC Publication/Presentation Doctor's Office/Hospital Advanced Directive Other: _____

RELIGIOUS AFFILIATION (optional): _____

Worksheet for Education and Race/Ethnicity (for Reference only)

Notice to Informants (aka responsible party/survivor): The information requested is essential for determining the health problems of the population groups noted below and your cooperation is appreciated. Completion of this work sheet in conjunction with the "Certificate of Death" is mandatory.

DECEDENT'S

EDUCATION - Check the box that best describes the highest degree or level of school completed at the time of death.

Enter appropriate information on Page 3

- 0-11th grade.
Enter highest year completed: _____
- 12th grade, but no diploma.
Enter 12
- High school graduate or GED completed. Enter either HS GRADUATE or GED: _____
- Some college credit, but no degree. Enter SOME COLLEGE
- Associate degree (e.g., AA, AS). Enter ASSOCIATE
- Bachelor's degree (e.g., BA, AB, BS). Enter BACHELOR'S
- Masters degree (e.g., MA, MS, MEng, ME d, MSW, MBA). Enter MASTER'S
- Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD). Enter either DOCTORATE or PROFESSIONAL.

WAS DECEDENT SPANISH/HISPANIC/LATINO?

If not Spanish/Hispanic, check "NO" on Page 3.

If Spanish/Hispanic check "YES" on Page 3 and enter specific origin.

- No
- Yes, Mexican, Mexican American, or Chicano
- Yes, Central American
- Yes, South American
- Yes, Cuban
- Yes, Puerto Rican
- Yes, other - Spanish/Hispanic/Latino

Specify: _____

WHAT WAS DECEDENT'S RACE OR ETHNICITY? (Check one or more races to indicate what the decedent considered himself or herself to be)

Enter text for up to 3 races on Page 3

- White
- Black, African American, or Negro
- American Indian or Alaska Native (North, South, and Central American Indian)
Specify Tribe(s) _____
- Native Hawaiian
- Guamanian
- Samoan
- Other Pacific Islander
Specify: _____
- Asian Indian
- Cambodian
- Chinese
- Filipino
- Hmong
- Japanese
- Korean
- Laotian
- Vietnamese
- Other Asian
Specify: _____
- Other
Specify: _____

Race Abbreviations:
 American Indian = AMER IND
 Cambodian = CAMBODIA
 Guamanian = GUAMIAN

Asian Indian = SIA IND
 Vietnamese = VIETNAM
 Pacific Islander = PACIF IS

UNIVERSITY OF CALIFORNIA DONATION AGREEMENT

1. INFORMATION ON THE DONATED BODY PROGRAM

The UC Anatomical Donation Program at (also known as the donated body, body donation, willed body or anatomical materials program, but referred to as “Program” in this document) accepts donations of human bodies for use by various institutions and individuals for education and research purposes. The Program’s goals are:

1. Assisting the education of current and future physicians, other healthcare practitioners, anatomists, forensic scientists and mortuary technicians.
2. Contributing to scientific research that will assist in development of procedures and/or products with the intent of improving the human condition in biomedical and scientific contexts.

Based on the Program’s current and future policies and procedures, the Program will exclusively determine the manner in which a donated body and any data, including images, derived from the donation will be utilized. The Program may support others in the development of commercialized products in a limited manner; for example, with the use of non-identifying images in text books or other instances where the primary benefit of the use is for education and research. Section 3 of this donation agreement provides additional information about the use of bodies donated to UC.

When this agreement has been completed and the Program has confirmed registration, the donor will be provided with a Donor Card that contains the necessary information to contact the Program at the time of death.

Donations will remain confidential. Once a donor’s remains have been accepted into the Program, acknowledgement will be sent only to the person, or persons, designated by a donor in this application. “Donor” as used in this agreement means the individual whose body or part is the subject of the anatomical gift.

Due to the nature and variability of uses for scientific research and education, **cremated remains or any by-products of the cremation process WILL NOT be returned.** By signing this agreement, you, as a donor or a donor’s legal representative, acknowledge that remains will not be returned and specifically waive the provisions of California Health & Safety Code Section 7151.40(b) that provides for the return of cremated remains to certain individuals. The Program will not offer exceptions to this policy and encourages potential donors to consider the impact of this policy on their families or communities.

Initials_____

2. INSTRUCTIONS FOR SURVIVORS (RESPONSIBLE PARTY)

1. Upon the death of a donor, please notify the Program of the death immediately, as a delay can result in rendering the remains unusable to the Program. Please ensure that body is not embalmed and is otherwise unprepared.
2. Although every effort will be made to accept a donor’s body, the Program may decline a donation at the time of death at its sole discretion. While this situation is unusual, please consider alternative arrangements for the disposition of the body should the body be deemed unsuitable for donation.
3. The University of California accepts donations throughout the State of California and, in special circumstances, from neighboring states. Upon notification of a donor’s death, donors are typically received by the campus program location that is geographically closest. However, the university shall have the option of:
 - a. arranging for the body to be accepted by any University of California Anatomical Donation Program location.
 - b. declining to accept the donation of the body.
4. The Program will have an original certificate of death filed with the county where death occurs, in compliance with the Registrar of Births and Deaths. The donor’s responsible party must obtain necessary copies of the certificate of death. The Program will provide the contact information for the local Registrar.
5. Third-party donations (for example, donations made by an Agent named on a Durable Power of Attorney for Health Care or the person who has control over the disposition of the decedent’s body) may also be accepted. Individuals making third-party donations must sign the required documentation found in this agreement specifying that they are compliant with the stated criteria.
6. Upon a donor’s death, the Program will send an acknowledgement letter to a family member or friend (the person or persons you have designated in the fields below) or may contact that person to verify information for the certificate of death or for other reasons. You may decline to designate a recipient or you may designate more than one person. If you are signing on behalf of the donor, you may designate yourself.

Name(s) _____ Relationship(s): _____

Address: _____

City/State/Zip code: _____

Phone number/E-mail: _____

OR

I elect not to name a recipient: _____

Initials _____

USE OF DONATED BODIES

Whole body donors may be used in the following manner:

1. The program will determine medical suitability of a donated body through a process that may include review of medical records, a medical or social history questionnaire and/or serology testing. Testing may include obtaining a blood sample to screen for Hepatitis B, Hepatitis C, HIV, or other communicable diseases that may render the body as medically unsuitable for donation. Results of tests will not be disclosed to the donor's designated survivor/responsible party but will be reported to the California Department of Health Services if mandated by law.
2. A donated body may be chemically preserved by the Program or used in a non-embalmed state as anatomical material.
3. A donated body may be dissected, examined, studied, and preserved for a substantial period of time, including the possibility of permanent retention, and may be used for more than one purpose. Parts of the body such as limbs or organs may be removed and separated from the whole. Bodily fluids and tissues may be analyzed and destroyed.
4. A donated body and/or part of the body may be provided to educators, students, researchers or others at University of California campuses, as well as to other educational institutions, researchers, non-profit entities and entrepreneurial entities, such as those who develop surgical instruments or healthcare products. When a donation is made, donors, survivors and/or responsible parties **cannot** designate the uses to which the body will be put nor the persons or entities that will use the body. The University of California reviews requests for uses and approves them on a case-by-case basis according to their scientific and educational merit.
5. The Program may support the development of commercialized products in a limited manner when the primary benefit of the use is for education and research (for example, in textbooks, or educational software).
6. Donor data, including health data and images, derived during the registration, donation or use may be used for education and research purposes. Data will be de-identified and stored or shared securely.
7. The Program shall be entitled to recover all of its acquisition, preservation, storage, transportation, disposition and related costs (both fixed and non-fixed) from the approved researcher or educator (end-user).
8. If it is determined that, for any reason, a body cannot be used by the Program, or by any educator or researcher approved for use of anatomic material donated to the Program, it will be cremated or undergo a final disposition in a manner consistent with the existing California law. Personal belongings received with a body including eyeglasses, dentures or pacemakers may be donated, refurbished or recycled. Other items such as clothing or bedding will be discarded.

Initials _____

3. DISPOSITION OF DONATED BODIES

The following applies to the ultimate disposition of donor bodies by the Program. By signing this Agreement, a donor or his/her responsible party authorizes the Program and its agents to dispose of the donor by cremation or by another legal manner that may be approved at the time of death.

1. Because parts of the body may be removed during its use, these parts may be disposed of at different times and at different locations. Upon completion of the use of the body or any part of the body, the material may be cremated or otherwise disposed of by any means permitted under state law in effect at the time of disposition.
2. Under certain circumstances, body parts, tissue and fluids may undergo disposition with material from other donors, in accordance with California law.
3. Survivors/responsible parties will not be notified of the time, place or manner of the disposition of a body or any part of a body, or of the final disposition of the remains. The cremation of some parts of the body may not result in the creation of any remains for disposition due to the composition of those body parts.
4. The donor or legally responsible person signing on behalf of the donor expressly waives the provisions of California Health & Safety Code Section 7151.40(b) that provides for the return of cremated remains. Due to the nature and variability of uses for scientific research and education, **cremated remains or any by-products of the cremation process WILL NOT be returned.**

Initials _____

5. INFORMATION ON HOW TO REVOKE A DONATION

Donations may be revoked in accordance with the California Health and Safety Code. The process to revoke a donation is different for a person donating his/her own body (self-donation) and for a donation made by another (authorized person). Please read and acknowledge your understanding of how to revoke a donation by affixing your initials.

1. Self-Donation

A donor may revoke an anatomical donation at any time prior to death. *After death, this donation cannot be revoked by survivors/responsible parties and survivors/responsible parties cannot change any term or condition of the gift.* By signing this agreement, a donor intends for the University of California to have the exclusive right to control the use and disposition of their body upon death.

2. Donation made by another authorized person

An authorized person, other than the decedent, who has the legal right to make a donation according to California Health and Safety Code 7150.40, may revoke an anatomical donation only if, before an incision is made or an invasive procedure has begun to prepare the donor, the Program is made aware of the revocation.

Initials _____

PLEASE COMPLETE SECTION 6 IF YOU ARE SIGNING FOR YOURSELF. IF YOU ARE SIGNING ON BEHALF OF THE DONOR, PROCEED TO SECTION 7. PLEASE NOTE THAT ONLY THE DONOR OR AGENT WITH DURABLE POWER OF ATTORNEY FOR HEALTHCARE MAY SIGN PRIOR TO THE DEATH OF THE DONOR.

6. PLEASE COMPLETE THIS SECTION WHEN SIGNING FOR YOURSELF.

I, _____, hereby donate my body upon my death to the University of California pursuant to the terms and conditions set forth herein. I am at least 18 years of age. I adopt these descriptive and declarative terms and conditions as my own and make them my instructions for the disposition of my body upon my death. I have read and considered all of the information contained in this Donation Agreement. I have initialed each section of the Agreement indicating my understanding of the information and my desire to donate my body pursuant to this Agreement.

Signature _____ Date: _____

Print Name _____

Address: _____

City/State/Zip code _____

Phone/E-mail _____

TWO WITNESSES OR NOTARIZATION REQUIRED

This agreement must be either signed by two witnesses, with at least one as a “disinterested witness”, OR may be notarized by a notary public in lieu of witnesses if you are signing this donation agreement for yourself.

1. WITNESSES

“Disinterested witness” means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of donor, or another adult who exhibited special care and concern for the individual.

We, the undersigned, have witnessed the signing of this document by the donor.

Signature of Witness

Signature of Disinterested Witness

Print Name

Print Name

Address

Address

City/State/Zip

City/State/Zip

2. NOTARIZATION

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California

County of _____

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under penalty of perjury under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
(Signature of Notary Officer)

(Seal)

7. PLEASE COMPLETE THIS SECTION IF YOU ARE THE SPOUSE, REGISTERED DOMESTIC PARTNER, AGENT NAMED IN THE DURABLE POWER OF ATTORNEY FOR HEALTHCARE OR THE PERSON WHO HAS CONTROL OVER THE DISPOSITION OF THE DECEDENT’S BODY.

I have read and fully understood the policies set forth in this document. As the legally responsible party under this section for _____ (name of deceased) I wish to donate his/her remains to the University of California. I accept all terms and conditions set forth in this document and I know of no express, contrary information indicating that the decedent would not want to donate his/her body.

____ I am the spouse of the deceased donor.

____ I am the registered domestic partner of the deceased donor.

____ I am the agent for the donor with power of attorney for health care and I have the right and duty of disposition under Division 4.7 (commencing with Section 4600) of the Probate Code or, I have been designated to control the donor’s disposition in an Advance Health Care Directive. **A copy of the Durable Power of Attorney for Healthcare or Directive must be attached.**

____ I am the declared claimant of the deceased donor and have completed the attached affidavit in support of this claim

Signature	Relationship to Decedent	Date
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Print Name

Address	City/State/Zip
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Phone/E-mail

TWO WITNESSES REQUIRED

This agreement must be signed by two witnesses, with at least one as a “disinterested witness”.

1. WITNESSES

“Disinterested witness” means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of donor, or another adult who exhibited special care and concern for the individual.

We, the undersigned, have witnessed the signing of this document by the donor.

Signature of Witness

Signature of Disinterested Witness

Print Name

Print Name

Address

Address

City/State/Zip

City/State/Zip

**8. Affidavit In Support of Claim to
Control Disposition of Bodily Remains
Pursuant to Health and Safety Code Section 7100**

PLEASE COMPLETE THIS SECTION IF YOU ARE THE PERSON WHO HAS CONTROL OVER THE DISPOSITION OF THE DECEDENT'S BODY.

Name of Decedent _____

Name of Claimant _____

Address of Claimant _____

Phone Number _____

Relationship to Decedent _____

***I claim the right to control the disposition of the Decedent's bodily remains because:
(check all that apply)***

- The Decedent named me to control the disposition of his or her body in a will or other document (attach a copy of the document).

- I am the Decedent's (circle one) *child, parent, grandparent* or *nearest other relative*. (If you are the Decedent's child, you must have the approval of the majority of the Decedent's children to arrange the disposition of the body. By signing below, you represent that you have the approval of the majority of the Decedent's children or that you have made reasonable efforts to notify all of the Decedent's other children of your arranging the disposition of the Decedent's body).

I am not aware of any person who objects to my arranging the disposition of the body of the Decedent.

I am not aware of any written or oral instruction by the Decedent, or any contract for funeral services by the decedent, that give control of the disposition of the Decedent's remains to any other person.

I am aware of and have received a copy of Health and Safety Code Section 7100 and agree to comply with the provisions therein.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____

Date _____

HEALTH AND SAFETY CODE SECTION 7100

7100. (a) The right to control the disposition of the remains of a deceased person, the location and conditions of interment, and arrangements for funeral goods and services to be provided, unless other directions have been given by the decedent pursuant to Section 7100.1, vests in, and the duty of disposition and the liability for the reasonable cost of disposition of the remains devolves upon, the following in the order named:

(1) An agent under a power of attorney for health care who has the right and duty of disposition under Division 4.7 (commencing with Section 4600) of the Probate Code, except that the agent is liable for the costs of disposition only in either of the following cases:

(A) Where the agent makes a specific agreement to pay the costs of disposition.

(B) Where, in the absence of a specific agreement, the agent makes decisions concerning disposition that incur costs, in which case the agent is liable only for the reasonable costs incurred as a result of the agent's decisions, to the extent that the decedent's estate or other appropriate fund is insufficient.

(2) The competent surviving spouse.

(3) The sole surviving competent adult child of the decedent, or if there is more than one competent adult child of the decedent, the majority of the surviving competent adult children. However, less than the majority of the surviving competent adult children shall be vested with the rights and duties of this section if they have used reasonable efforts to notify all other surviving competent adult children of their instructions and are not aware of any opposition to those instructions by the majority of all surviving competent adult children.

(4) The surviving competent parent or parents of the decedent. If one of the surviving competent parents is absent, the remaining competent parent shall be vested with the rights and duties of this section after reasonable efforts have been unsuccessful in locating the absent surviving competent parent.

(5) The sole surviving competent adult sibling of the decedent, or if there is more than one surviving competent adult sibling of the decedent, the majority of the surviving competent adult siblings. However, less than the majority of the surviving competent adult siblings shall be vested with the rights and duties of this section if they have used reasonable efforts to notify all other surviving competent adult siblings of their instructions and are not aware of any opposition to those instructions by the majority of all surviving competent adult siblings.

(6) The surviving competent adult person or persons respectively in the next degrees of kinship, or if there is more than one surviving competent adult person of the same degree of kinship, the majority of those persons. Less than the majority of surviving competent adult persons of the same degree of kinship shall be vested with the rights and duties of this section if those persons have used reasonable efforts to notify all other surviving competent adult persons of the same degree of kinship of their instructions and are not aware of any opposition to those instructions by the majority of all surviving competent adult persons of the same degree of kinship.

(7) The public administrator when the deceased has sufficient assets.

(b) (1) If any person to whom the right of control has vested pursuant to subdivision (a) has been charged with first or second degree murder or voluntary manslaughter in connection with the decedent's death and those charges are known to the funeral director or cemetery authority, the right of control is relinquished and passed on to the next of kin in accordance with subdivision (a).

(2) If the charges against the person are dropped, or if the person is acquitted of the charges, the right of control is returned to the person.

(3) Notwithstanding this subdivision, no person who has been charged with first or second degree murder or voluntary manslaughter in connection with the decedent's death to whom the right of control has not been returned pursuant to paragraph (2) shall have any right to control disposition pursuant to subdivision (a) which shall be applied, to the extent the funeral director or cemetery authority know about the charges, as if that person did not exist.

(c) A funeral director or cemetery authority shall have complete authority to control the disposition of the remains, and to proceed under this chapter to recover usual and customary charges for the disposition, when both of the following apply:

(1) Either of the following applies:

(A) The funeral director or cemetery authority has knowledge that none of the persons described in paragraphs (1) to (6), inclusive, of subdivision (a) exists.

(B) None of the persons described in paragraphs (1) to (6), inclusive, of subdivision (a) can be found after reasonable inquiry, or contacted by reasonable means.

(2) The public administrator fails to assume responsibility for disposition of the remains within seven days after having been given written notice of the facts. Written notice may be delivered by hand, U.S. mail, facsimile transmission, or telegraph.



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FAX 310-794-0334

Donor's Legal Name – First	Middle	Last
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I certify that pursuant to Section 7100, Health & Safety Code, State of California, it is my legal right to select a disposition service. Therefore, please release the body of the above deceased to the custody of the David Geffen School of Medicine UCLA Donated Body Program.

Donor OR Agent with DPOA for HealthCare Must Sign:

Please sign where indicated. This form is used only when a signed release is required from a hospital or other institution to obtain custody of the body.

Signature: X	Relationship: <i>(Write Donor or Agent)</i>
Print Full Name:	
Address of Donor or Agent:	
Address:	
City:	State:
Zip:	
Phone:	Date:

Privacy Act Notification



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STATE

The California Information Practices Act of 1977 requires the University to provide information to the individual to whom the information pertains.

Furnishing information requested in the Vital Statistic sheet is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form will be transmitted to the state and federal governments if required by law.

Civil Code Section 1798.9 et seq. requires each state agency to provide notice to individuals completing this form (VS-11 Certificate of Death and VS 9 Application and Permit for Disposition of Human Remains). The information is being requested by: Department of Health Services, Office of Vital Records, 304 S Street, P.O. Box 730241, Sacramento, CA 94244-0241. The information requested on this certificate is authorized as required by Divisions 7 and 102 of the Health and Safety Code, and related provisions with the Civil Code, Code of Civil Procedure, and Government Code.

The principal purpose for this record is:

1. To establish a permanent record that is legally recognized as prima facie evidence of the facts stated therein for each death occurring in the State of California.
2. To provide information, to health authorities and other qualified persons with a valid education or scientific interest, for demographic and epidemiological studies for health and social purposes.
3. To provide information to the National Center for Health Statistics for compiling national statistical reports, and to state and federal agencies for file clearance purposes.
4. To provide individuals with certified copies from the records to serve their personal needs, such as applying for social security or death benefits.

Individuals have the right to review their own records in accordance with the Information Practices Act and University policy. The record shall be open for examination during regularly scheduled office hours, except when access is specifically prohibited by statute or regulations.

The State of California Health and Safety Code Section 7054.6, 7117 and 10376, and related provisions in the Civil Code, Code of Civil Procedure, and Government Code, authorize maintenance of this information. The director responsible for maintaining the information contained on this form is the Body Donation Program Director, University of California San Diego, School of Medicine, 9500 Gilman Drive, MC 0627, La Jolla, CA 92093.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. Disclosure of the social security number is required pursuant to the regulations of the State Registrar of Vital Statistics. The social security number is used to verify your identity.

HIPAA (Health Insurance Portability and Accountability Act) laws and how they relate to the reporting of vital event records.

The information necessary to complete the Certificate of Birth and Certificate of Death is required by California State law (Health & Safety Code Sections 102425 and 102875 respectively). The Privacy Rule permits covered entities to disclose PHI (Protected Health Information), without authorization, to public health authorities or other entities that are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury and reporting of vital event records, such as births and deaths (Reference 45 Code of Federal Regulations (CFR) Section 164.512).

Change of Statistical Information

USE THIS FORM ONCE YOU ARE REGISTERED TO CHANGE INFORMATION



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To report a change of address, marital status or other pertinent information, please complete this form and mail it to the UCLA Donated Body Program. Accuracy in your reporting changes helps ensure that data will be recorded correctly.

The Donor's name: _____

Change in Donor's address:

Former Street: _____

City/State/Zip: _____ Phone: _____

Current Street: _____

City/State/Zip: _____ Phone: _____

Change in Marital Status:

Widowed Married Divorced Re-married Registered Domestic Partner

Change in Name: _____

Other: _____

Mail Original Signed Copies to:

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PO Box 957340
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Telephone 310-794-0372
FAX 310-794-0334