

## Body Donation Packet

This packet contains all the forms required for registering with our body donation program; policy sheet, body donation document, and body donation questionnaire. Please feel free to contact us with any questions you may have. Please read the packet in its entirety.

1. **Body Donation Program Policy Document.** Please read, sign, and have your signature witnessed by two individuals.
  
2. **Body Donation Form**
  - A. We need one original copy of the body donation form with a valid signature returned with your donation paperwork. Copies of this form should be retained by you and/or your family for your records.
  
  - B. Signatures on the form
    - a. The top portion of the form is to be completed by the Donor. The Donor should be of legal age and sound mind and aware of the nature of our program at the time of signing.
    - b. The middle portion is to be completed by two adult witnesses. At least one witness should be a “disinterested witness”, meaning someone other than a close family member, guardian, or a person who exhibits a special care for the Donor.
    - c. A notary is not required for completion of this portion of the form.
  
  - C. Special Requests. Please state any special requests you may have as to how we use your remains at the bottom of this document or on an attached sheet. We will make every effort to honor any requests.
  
3. **Biological Questionnaire**
  - A. Please complete this form to the best of your ability.
  
  - B. Information provided contributes information for our research.
  
  - C. We ask that any changes of your statistical information be forwarded to us (ex. Name change, address change, significant health changes) in order for us to keep our record updated.
  
  - D. Please provide a picture of yourself. A frontal view of the face is preferred, such as on your driver’s license or passport. This will be used for research involving facial reconstruction and photographic superimposition as a means of identifying unknown individuals can first be conducted on known individuals.

### Acceptance into Program

Acceptance into our donation program will be determined once forms are completed and mailed back to us. Please see points 2 and 4 in the Program Policy Sheet.

You will receive a letter of acceptance and a Donor card with contact information to carry in your wallet.



## Body Donation Program Policy

The donation of a person's body after death is a tremendous gift. We are grateful for everyone who expresses an interest in body donation. We appreciate your attention to the following.

1. Unlike medical schools, we do not return remains to the family. The skeletal remains are a very important component to our research and teaching program.
2. We reserve the right to decline donations of individuals who have some form of infectious disease such as HIV, tuberculosis, hepatitis of any kind, or antibiotic resistant infections such as MRSA, even if contracted after donation is arranged. **EMBALMED BODIES CANNOT BE ACCEPTED.**
3. Donors with an infectious disease who still wish to donate may do so by choosing to have their remains cremated. A collection of cremated remains provides an invaluable learning resource. People choosing this option should contact us prior to making arrangements. This allows us to work with the crematory involved to ensure the remains are not pulverized. The family must assume responsibility for the arrangement and cost of cremation.
4. We also reserve the right to decline a donation if our facility is at capacity. In case of denial by the University, alternate final arrangements should be discussed by the Donor and/or the family.
5. The determination of acceptability shall be made by CMU in its sole discretion.
6. We will arrange transportation to our facility if the deceased is located 75 miles of Grand Junction, CO. Outside the designated area, the Donor and/or the Donor's family must make arrangements for the transportation of the body to our facility and assume responsibility for any associated costs.
7. We need to have signed donation documents prior to transporting. This may be a faxed copy, but the original must be sent as soon as possible. Your donation paperwork will not be complete until originals are returned. An authorization for final disposition needs to accompany the body.
8. Pre-Donor paperwork needs to be returned to the Forensic Investigation Research Station at the time of completion in order for a file to be established. Changes of address or medical status should be sent to keep Donor files up to date.
9. Pre-Donor paperwork needs 2 witnesses to verify your signature, but does not need to be notarized.
10. We do not perform autopsies to determine cause of death on donations to our program. In Colorado, the Coroner should determine that no autopsy is needed before the donation is released to our program.

If you have any questions or concerns that have not been addressed in this letter, please feel free to contact us at 970-248-1219 or email [FIRS@coloradomesa.edu](mailto:FIRS@coloradomesa.edu).

I have read, understand, and agree to the body donation policy of the Colorado Mesa University Forensic Investigation Research Station.

\_\_\_\_\_  
Printed name of Donor/ Next of Kin/Executor

\_\_\_\_\_  
Signature of Donor/ Next of Kin/Executor

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Phone number with area code, E-mail (optional)

\_\_\_\_\_  
Printed name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Phone number with area code, E-mail (optional)

\_\_\_\_\_  
Printed name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Phone number with area code, E-mail (optional)

**Body Donation Document**

Date	Social Security Number
Donor's Name (please print)	
Address	

It is my wish that at the time of my death, my body be made available for teaching and scientific purposes to Colorado Mesa University's Forensic Investigation Research Station and that it not be returned to my next of kin or any other recipient. I understand that Colorado Mesa University will pay for transportation of my body as long as it is located within a 75 mile radius of Grand Junction, CO.

I understand that the Forensic Investigation Research Station reserves the right to decline donations. If the Forensic Investigation Research Station is unable to use my body for these or other reasons, my next of kin must make other final disposition arrangements. The Forensic Investigation Research Station is not responsible for any costs associated with other necessary arrangements.

At the time of my death, I hereby relinquish all rights and claims regarding my body and direct that by accepting and using my body for teaching and scientific purposes and its subsequent disposition, neither the State of Colorado nor Colorado Mesa University nor the Forensic Investigation Research Station shall incur any liability and no manner of claim shall arise against the State of Colorado nor Colorado Mesa University nor the Forensic Investigation Research Station.

- [ ] If I die outside of a 75 mile radius of Grand Junction, CO my estate or next of kin pays the cost of transporting my body to Colorado Mesa University.
- [ ] I wish for my remains to be used for trauma research that will provide the foundation for training professionals in life saving techniques and in the construction of equipment that would enhance and/or prevent the need for these measures.
- [ ] I wish for my remains to be used in research on the impact of fire on human remains as it pertains to forensic casework, a subject greatly in need of further study.

Body Donor Signature: \_\_\_\_\_

(Witness)	(Witness)
(Address)	(Address)
(Name of next of kin)	(Signature of next of kin)
(Address)	(Relationship to Donor)



Biological Questionnaire

Please complete the following information by filling in the blank and/or circling an option. If you need more space, additional sheets may be attached. All of the information will be considered confidential.

Name Last / First / Middle Sex: male \_\_\_ female \_\_\_ Age \_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Phone Number \_\_\_ Military Service: yes \_\_\_ no \_\_\_

Social Security # \_\_\_-\_\_\_-\_\_\_ Place of Birth (city/state): \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: (circle one): Never Married Married Widowed Divorced Unknown Other

Spouse: Last (include maiden) / First / Middle Living \_\_\_ Deceased \_\_\_ Unknown \_\_\_

Number of Children: \_\_\_\_\_

Parents' Full names (include maiden names)

Name Sex: male \_\_\_ female \_\_\_ Place of Birth \_\_\_\_\_

Name Sex: male \_\_\_ female \_\_\_ Place of Birth \_\_\_\_\_

Highest Education Level (indicate number of years): \_\_\_ Highest Degree Earned: \_\_\_ Elem/Second (0-12): \_\_\_ College (1-4; 5+): \_\_\_

Usual (life-long) Occupation \_\_\_\_\_ Business/Industry \_\_\_\_\_

Childhood Socio-Economic Status: (circle one): Lower Lower Middle Middle Upper Middle Upper

- Race - Check all that apply: White, Black, Native American, Hispanic, Asian, Pacific Islander, Other

PLEASE CONTINUE ON NEXT PAGE

Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle

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**Residence History** (list additional locations as necessary)

Childhood Hometown (0-15 years of age):

City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Location as an Adult (any place you have lived for more than 1 year)

City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

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**Dental History** – Check all that apply:

- |   |   |                               |
|---|---|-------------------------------|
| <input type="checkbox"/> Extensive Dental work                | <input type="checkbox"/> Most/all teeth | Teeth Missing:                |
| <input type="checkbox"/> Lower Dentures: When _____           | <input type="checkbox"/> Bridge         | <input type="checkbox"/> Few  |
| <input type="checkbox"/> Upper Dentures: When _____           | <input type="checkbox"/> Gum Disease    | <input type="checkbox"/> Many |
| <input type="checkbox"/> Upper and Lower Dentures: When _____ | <input type="checkbox"/> Dental Disease | <input type="checkbox"/> All  |
| <input type="checkbox"/> Partial Plate                        | <input type="checkbox"/> Other _____    |                               |
| <input type="checkbox"/> Braces                               | _____                                   |                               |
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**Medical History (please indicate the approximate year for each).** Please do not provide just a Doctor's name.

- |   |   |
|---|---|
| <input type="checkbox"/> Surgery (general): _____<br>_____<br>_____   | <input type="checkbox"/> Plastic Surgery (indicate type and location)<br>_____<br>_____       |
| <input type="checkbox"/> Fractures _____<br>_____<br>_____  | <input type="checkbox"/> Cancer (type): _____<br>Treatment: _____<br>Length of Illness: _____ |
| <input type="checkbox"/> Auto Accident (with traumatic injury)<br>YR: _____   | <input type="checkbox"/> Smoker? If yes, how long? _____                                      |
| <input type="checkbox"/> Spinal Injuries YR: _____  | <input type="checkbox"/> Alcoholism YRS: _____  |
| <input type="checkbox"/> Open Heart Surgery YR: _____   | <input type="checkbox"/> Diabetes Type: _____   |
| <input type="checkbox"/> Prosthetics (e.g. Hip or knee replacement)<br>Type/Yr: _____<br>Type/Yr: _____<br>Type/Yr: _____ | <input type="checkbox"/> Other (Including childhood disorders):<br>_____<br>_____             |
- 

**PLEASE CONTINUE ON NEXT PAGE**

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Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle

**Medical History (continued)** – Please describe the above and any other information you feel may be important, including current medications, timing of injuries, the locations of traumatic injuries, or a family history of an illness, etc. Please attach additional pages as necessary.

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**Habitual Activities** (i.e., jogging, repetitive motions, life-long occupation activities, etc.) -

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**Driver's License Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Recent Weight Loss:** yes \_\_\_ no \_\_\_

**Handedness:** Right \_\_\_ Left \_\_\_ **Shoe size** \_\_\_\_\_ **Hair Color** \_\_\_\_\_

**Eye Color:** Blue Green Gray Brown Hazel Other: \_\_\_\_\_

**Tattoo(s)**  Yes  No If yes, Description: \_\_\_\_\_  
Body Location: \_\_\_\_\_

**Body Piercings(s)**  Yes  No If yes, Description: \_\_\_\_\_  
Body Location: \_\_\_\_\_

**Next of Kin Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ email: \_\_\_\_\_

**PLEASE CONTINUE ON NEXT PAGE**



Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle

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**Informant Information (if other than Donor or Next of Kin)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ email: \_\_\_\_\_

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**DO NOT CONTINUE IF YOU ARE A LIVING DONOR**

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Location of death (if applicable): \_\_\_\_\_ Date of Death \_\_\_\_\_

Institution/Hospital \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

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Thank you for taking the time to fill out this questionnaire.  
If we can be of further assistance, please feel free to contact us.

**Return completed forms to:**

Dr. Christiane Baigent  
Forensic Investigation Research Station  
Colorado Mesa University  
1100 North Avenue  
Grand Junction, CO 81501

Phone: 970-248-1219

Email: [FIRS@coloradomesa.edu](mailto:FIRS@coloradomesa.edu)