Restore Life USA

Donor Consent Form

Legal Name of Donor (person being donated) _____Date of Birth _____.
Name of person consenting for donation:_____.

Person authorized to consent to donation, if other than "myself", must be legal next of kin (closest in relation to Donor). Relationship is listed below in legal priority order. Relationship of person granting consent of donation is (check only one box):

□ Myself
□Spouse
□Son or Daughter 18 years or older (Total Number of Children 18 years or older: _____. All Must Sign/Participate)
□Parent (Total Number of Living Parents: _____. If Both Living, Both Must Sign/Participate)
□Brother or sister over 18 (Number of Siblings 18 years or older: _____. All Must Sign/Participate)
□Guardian of the decedent at the time of death
□An individual in the next degree of kindred
□The personal representative of the estate of the decedent
□The person nominated as the personal representative in the decedent's last will

Hereby grant consent for:

□Entire body to Restore Life USA with remains for cremation – _____will receive partial cremated remains where the contracted crematory will make all reasonable effort to avoid the potential from comingling of cremains.
□ Entire body to Restore Life USA without remains – cremated remains will be honored in a memorial scattering and family will NOT receive any cremated remains.

The decision to donate Is private and confidential. I authorize Restore Life USA to obtain all necessary tissue and organs for research and educational purposes. I understand this gift will be used for scientific research, teaching, genetic testing (not linked to donor's identity) or other conforming purposes (and that this use may involve dissection and/or anatomical disarticulation or segmentation, e.g. removal of extremities, preservation, photography/imaging, and/or distribution), and for use in multiple research or educational venues with for profit and/or non-profit organizations (domestic and international), and possible commercial applications such as discovery and development of treatment, drugs, or testing that Restore Life USA, in their sole discretion, to facilitate the gift.

After death, I authorize any and all medical information to be released to Restore Life USA, I authorize Restore Life USA to obtain a complete medical history, autopsy findings and blood samples. I understand that blood testing may include but is not limited to HIV, hepatitis B and C. Restore Life USA reserves the right, at its sole discretion, to decline acceptance of the donation if it appears unsafe or unsuitable for the purposes consented to herein or if the donor is severely obese. Restore Life USA does not perform autopsy or pathology services and as such no report on the finding will be provided. I understand that all donor information will remain anonymous and non-identifying health related data may be shared with investigators and commercial entities. I am making this gift freely and voluntarily, without obligation of any kind on the part of Restore Life USA and there will be no reward of compensation to me or any family member. I understand that partial cremated remains will be returned to the legal next-of-kin within 30 days of donation. I understand that an "open casket viewing" is not possible with any whole body donation and viewing of any type is not feasible once Restore Life USA has taken possession of the body. No un-cremated remains will be returned. I understand that neither I nor any member of my family will be responsible for any costs related to the donation. I understand that this is a legal document being signed by me or at my direction by another in accordance with the Uniform Anatomical Gift Act and Tennessee Anatomical Gift Statutes. I agree to hold harmless Restore Life USA and all associated agents including tissue users from loss or damage, including incidental and consequential damage that incurs which results from the undersigned not having proper legal authority to consent. Restore Life USA is hereby authorized to cremate the remains and reserves the rights to dispose of cremains and personal effects that are not claimed within 180 days from the date of donation in a manner consistent with Tennessee state law and other laws governing anatomical donation.

Completed consent *and* med/social forms must be returned to Restore Life USA and does not guarantee acceptance of donation until written or verbal notification of acceptance is provided. My signature demonstrates I understand the form and the donation process. I am unaware of any objection of any person authorized to grant consent in the same or higher legal priority for this donation.

Donor/Legal Next Of Kin Signature(s):_____Date: _____Time _____am/pm
Donor's Address:_____City:_____State_____Zip_____Phone Number"_____
Witness 1:_____Print Name_____Date_____Phone # _____
Witness 2:_____Print Name_____Date_____Phone #_____
Donor's Legal Next of Kin (Print):_____Relationship: _____
Address:_____City:_____State_____Zip_____Phone Number:_____

Mailing address 311 Cherokee Park Dr. Elizabethton, TN 37643 * 423-631-0067*Fax 423-631-0068*Fax after 5pm 865-381-1968

Restore Life USA

(Optional) Special Projects Donor Consent

Anatomical donations to Restore Life USA (RLU) are used for the advancement of clinical research and hands on medical training. The RLU medical director reviews each curriculum to determine its appropriateness for our donors. From time to time, a request is made to approve the involvement of RLU donors in special courses and research projects which will lead to improved knowledge, discovery, or care in the fields of battlefield medicine, forensic pathology, crime investigation, fire investigation, accident safety, development of protective equipment, and other vital scientific endeavors. Because the donor will be subjected to more extreme conditions that are likely to result in damage to the body, and are different in nature, extent, and duration from most educational and research uses, donor participation in these projects is voluntary and requires a separate detailed authorization. The completion of this consent form is **optional** and will not affect the decision to approve or deny any donor application for our program. Only anatomical donors who have an additional special consent on file will be considered for these projects.

I hereby offer my body and/or I give consent as the closest legal next of kin that after death the body of _____ can be used as an unrestricted anatomical gift to RLU. I understand that the acceptance and exact use of my anatomical donation will be at the discretion of RLU. In some cases such use may involve exposure to damaging forces (e.g., impacts, crashes, or ballistic injuries). Examples of how the gift might be used include medical education and training, forensic pathology, vehicle safety, or the development of protective equipment (e.g., military, law enforcement, or sports).

Your signature below authorizes the use of donor's body in a special project, including but not limited to the examples described above.

Signature: _____ Date: _____ Time: _____ am/pm

Please print or type name of Donor and/or Authorizing Party: _____

Witness #1: _____ Print Name: _____ Date: _____ Phone: _____

Witness #2: _____ Print Name: _____ Date: _____ Phone: _____

Restore Life USA Medical/Social History Questionnaire

Name:_____ Donor Number:_____
Age _____ Gender _____Ethnicity_____ Height (Feet/Inches) _____ Weight (Pounds) _____

All Blanks Must Be Answered With "Yes", "No", "N/A", And Dates Where Appropriate

Please circle his/her body stature: Underweight Healthy Weight Overweight Obese
If overweight or obese, circle where weight is distributed: Upper Body Lower Body Overall

His/her life-time surgical history and approximate dates: _____

_____

_____

If female, has she ever had hysterectomy? _____ If Y, partial or total: _____ Pre Or Post Menopausal?_____

Ever had a broken bone? ____ If so, which bone(s)?_____ Which Side(s)?_____
Casts/Splints/Surgery?_____ If surgery, has the hardware/pins/screws/plates been removed?_____
Ever had knee, hip, shoulder replacement? _____ Which joint(s)?_____ Side?_____ If Yes, When?_____

Does he/she have a history of cancer? _____ If yes, what type?_____
If yes and known, please list the specific form of the cancer type: _____
Month/Year diagnosed?_____Month/Year Last Treatment?_____ Chemo? Yes / No Radiation? Yes / No

Has he/she ever been exposed to/diagnosed with: AIDS/HIV?____ Hepatitis?____ What type?____ Covid-19?_____
COPD?_____ Asthma?_____ Emphysema?_____ Diabetes?_____ Type 1/2?_____ Gout?_____ Stroke?_____
Tuberculosis?_____ High Blood Pressure?_____ High Cholesterol?_____ Heart Attack?_____ Fatty Liver?_____
Rheumatoid Arthritis?_____ Osteoarthritis?_____ Which Joints?_____ Bed Sores?_____ Kidney Disease:_____
Osteoporosis?_____Cataracts? _____ Hypothyroidism?_____Irritable Bowel?_____ Colitis?_____ MRSA?_____
Crohn's Disease?_____ Psoriasis?_____ Epilepsy?_____ Jaundice?_____ Stomach Ulcer?_____ PTSD?_____
Hearing Loss/Deafness?_____ Wear Glasses Or Corrective Lenses?_____ Blindness?_____ Blood Clots?_____
Arrhythmias?_____ Heart Murmur?_____ Anemia?_____ Pancreatitis?_____ Gastric Reflux?_____ Angina?_____
Glaucoma?_____ Macular Degeneration?_____

Travel outside US in last 6 months?_____ Does he/she have a history of Creutzfeldt-Jakob (CJD) disease?_____
Any history of mental illnesses (including autism)? _____ If yes, please indicated which illness:_____
Medically Diagnosed with Alzheimer's?_____ Dementia?_____ Parkinson's Disease?_____ PTSD?_____
If Yes to any above, please provide date of diagnosis and any known tests/procedures used to confirm diagnosis:___

_____

Non-Medical Purpose/Street/Illicit Drug Use?_____ If yes, which drugs?_____
Method of Use (ex. Smoked, Injected, Snorted, Ingest): _____
Active Smoker?_____ Packs A Day?_____ How Many Years?_____ E-Cig User?_____ How Many Years?_____
Former Smoker? _____ If yes, date quit? _____ Alcohol: Never:____ Social:____ Abuse:_____ (Past or Present)

Circle his/her Covid-19 Vaccination Status: None First Shot Second Shot Booster Natural Immunity

Please list all prescribed medications:_____

_____

Please list any and all other medical conditions you have not already listed above and provide any specific details you wish to provide regarding any "Yes" response: _____

_____

_____

_____

Circle the best description of activity level in the last 6 months: Active Limited Wheelchair Bedridden

Restore Life USA Death Certificate Template

Responses will be utilized to file the death certificate with the state vital records department. We understand the urgency in having the certificate filed and made available to your loved ones. With that, we are asking that the responses be provided accurately, in a legible format, and in a timely manner. To further speed up the process of having the death certificate filed, we prefer the verification process with the informant (the individual tasked with working with us to file the death certificate and the recipient of the no charge certified death certificate we provide) takes place via email and we will ask for an email address below in the informant section. Revisions to filed death certificates may take up to 1 year to correct.

Donor's Information:

Legal First Name:_____ Middle: _____ Last: _____ Suffix: ____
Male: _____ Female: _____ Social Security Number:_____
Birthplace City: _____ Birthplace State: _____
Did He/She Reside In The City Limits: ___Yes ___No County Of Residence:_____
Occupation (Can Not Be Retired Or Disabled): _____
What Type Of Business Or Industry Was His/Her Occupation:_____

Military Service:

Did He/She Serve In The Armed Forces: ___Yes ___No If Yes, Which Branch:_____

Marital Information:

Current Marital Status (Please Check One):
___Married ___Married, But Separated ___Widowed ___Divorced ___Never Married ___Unknown
If Married or Married, But Separated, Provide Spouse's Full Name (Maiden Last Name):
First:_____ Middle:_____ Maiden Last:_____

Educational Level (Please Indicated Highest Level Completed):

___8th Grade Or Less ___Some College Credit, But No Degree ___Master's Degree
___9th-12th Grade, No Diploma ___Associate Degree ___Doctorate/Professional
___High School or GED ___Bachelor's Degree ___Unknown

Donor's Race:

___White ___Black or African American ___American Indian or Alaskan Native
___Chinese ___Filipino ___Japanese ___Korean ___Vietnamese ___Native Hawaiian
___Unknown ___Other (Specify):_____

Donor of Hispanic Origin:

___No, not Spanish/Hispanic/Latino ___Yes, Mexican/Mexican American/Chicano
___Yes, Puerto Rican ___Yes, Cuban
___Yes, Other Spanish/Hispanic/Latino (Specify)_____ ___Unknown

Parents Information:

Father First Name: _____ Middle Name:_____ Last Name: _____
Mother First Name:_____ Middle Name:_____ Maiden Last: _____

Informant's Information (Individual Responsible For Verifying Death Certificate Information):

Informant's Name: _____
Informant's Address: _____
City:_____ State:_____ Zip Code:_____
Informant's Relationship To Donor:_____
Informant's Telephone Number: _____ Informant's Email:_____