TOURO COLLEGE OF DENTAL MEDICINE
AT NEW YORK MEDICAL COLLEGE

Department of Cell Biology and Anatomy

Body Bequeathal Program - Confidential Statistical Information

Name:		
Present Address:		
Telephone Number:	Social Security No.:	
Date of Birth:	Place of Birth:	
Medicaid Number:	Sex: Female / Male	Race:
Are You a US Citizen? YES / NO If No, Please Specify:	Are You of Hispanic Origin? YES / NO If Yes, Country of Origin:	
Father's Name:	Mother's Name: _____ (Include Maiden Name)	
Your Occupation (Prior to Retirement): _____ Name of Business: _____ Type of Business: Location:		
War Veteran: NO / YES - War Served: Dates Served: From: To:		Last School Grade Completed
Marital Status:	Spouse's Name: _____ (For Wife, Include Maiden Name)	
Spouse's Address & Telephone Number (If Different From Yours):		
Name of Closest Relative:_____ Address:_____ Telephone Number:_____ Relationship to You:_____		
Request For Ashes To Be Returned ☐ YES ☐ NO Ashes will be available for return approximately 2 years from the time of death. If ashes are to be returned, please complete the following: Name of Individual to Receive Ashes:_____ Address:_____ Telephone Number: ( ) _____-_____Relationship To Donor:		
_____ Signature Date		