Body Bequeathal Program - Confidential Statistical Information
New York Medical College
Department of Cell Biology and Anatomy
Valhalla, NY 10595

| | | |
|---|---|---|
| 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<br>If No, Please Specify: | Are You of Hispanic Origin? YES / NO<br>If Yes, Country of Origin: | |
| Father's Name: | Mother's Name: _____<br>(Include Maiden Name) | |
| Your Occupation (Prior to Retirement): _____<br>Name of Business: _____<br>Type of Business: Location: | | |
| War Veteran: NO / YES - War Served:<br>Dates Served: From: To: | | Last School Grade Completed |
| Marital Status: | Spouse's Name: _____<br>(For Wife, Include Maiden Name) | |
| Spouse's Address & Telephone Number (If Different From Yours): | | |
| Name of Closest Relative: _____<br>Address: _____<br>Telephone Number: _____<br>Relationship to You: _____ | | |
| Request For Ashes To Be Returned ☐ YES ☐ NO<br>Ashes will be available for return approximately 2 years from the time of death<br>If ashes are to be returned, please complete the following:<br>Name of Individual to Receive Ashes: _____<br>Address: _____<br>Telephone Number: ( ) __ _____-_____Relationship To Donor: | | |
| Other Arrangements for Remains (explain): | | |
| _____<br>Signature Date | | |