



University of Florida  
College of Medicine  
P.O. Box 100235  
Gainesville, Florida 32610-0235  
1-800-628-2594 or 352-392-3588  
[www.med.ufl.edu/anatbd](http://www.med.ufl.edu/anatbd)

### Anatomical Board of the State of Florida Dedication Form

I, \_\_\_\_\_, the undersigned, desire that my body, at the time of death, be given to the Anatomical Board of the State of Florida for use in medical research and education. It is understood that the Anatomical Board of the State of Florida can accept my body only if I become deceased within the geographical limits of the State of Florida or if agencies or individuals other than the Anatomical Board assume responsibility for returning my body to the State of Florida.

It is also understood that this is a legal document in that it is a statement of my wish and intention to dedicate my body for medical use, as provided in Chapter 406 and Chapter 765 Part V, Florida Statutes. In order that this wish be promptly and effectively carried out after my death, I accept responsibility for obtaining the consent of all my relatives or close friends likely to have any concern about the final disposition of my body.

It is possible that an individual's body may be utilized for research or medical education outside of the State of Florida. Kindly strike out the appropriate word/words in the statement below to indicate approval or disapproval of such use. Also place your initials at the end of the statement.

I (do) (do not) object to the utilization of my body for medical research and education in an approved institution outside the State of Florida. \_\_\_\_\_ (Initial)

Signed in the presence of these witnesses of this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver License #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Witness Signature:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Witness Signature:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

Please print **TWO** copies of this form. Return one completed form with original signatures to the [Anatomical Board](#) and retain the second for your records.



[Donor's Instructions](#)

[Survivor's Instructions](#)



Email: [anatbd@dean.med.ufl.edu](mailto:anatbd@dean.med.ufl.edu)