IOWA
Carver College of Medicine

Deeded Body Program
Donor Information Sheet

Phone: (319) 335-7762 https://acb.medicine.uiowa.edu/deeded-body-program Fax: (319) 353-4394

Donor's Name (First, Middle, Last): _____

Donor's Maiden Name (If Applicable): _____ Date of Birth: _____

Place of Birth (City): _____ Place of Birth (State): _____

Current Address: _____

City: _____ County: _____ State: _____ Zip: _____

Residence within City Limits: ☐Yes ☐No Email Address: _____

Current Phone Number: _____ Cell Phone Number: _____

Social Security Number: _____ Sex (M/F): _____ Served in Armed Forces: ☐Yes ☐No

Usual Occupation: _____(Before Retirement) Kind of Business/Industry: _____

Donor's Father's Name (First, Middle, Last): _____

Donor's Mother's Name (Prior to any marriage): _____

Donor's Highest Level of Education: _____ Donor's Race (specify): _____

Donor of Hispanic Origin: ☐ No ☐ Yes, (Specify): _____

Name of Spouse (give maiden name if applicable): _____

Address of Spouse: _____

Telephone Number of Spouse: _____ Cell Phone number: _____

Person to contact after death (REQUIRED)

☐ Next-Of-Kin ☐Informant ☐ Designee

Name of Person: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Please give alternate contact (REQUIRED)

☐ Next-Of-Kin ☐Informant ☐ Designee

Name of Person: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

Email Address: _____