



**L-Università  
ta' Malta**

**DEPARTMENT OF  
ANATOMY**

**Faculty of  
Medicine & Surgery**

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**BEQUEATHAL FORM**

Please read the attached 'Information for Donors' before completing

**Part A:** to be completed by person making donation

Please complete in BLOCK CAPITALS

Title: \_\_\_\_\_ Surname/Family name: \_\_\_\_\_

Forename(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_ Tel no: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Religion/faith group (if applicable): \_\_\_\_\_

Nationality: \_\_\_\_\_

Identity card/Passport number: \_\_\_\_\_

***Brief Medical History***

Please provide a brief medical history (may attach as a letter signed by your Family Doctor or a General Practitioner). Important disorders such as severe illnesses, contagious serious infections, accidents or wounds, and all operations should be mentioned, but not common or minor illnesses. Give approximate dates, the names of doctors who attended you and state if you were treated as an in-patient and the name of the hospital. Such information may give leads to points of medical or surgical interest.

Provide the: name, address and contact number of your Family Doctor/General Practitioner:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Data Protection statement***

The information supplied on this form will be used by the University of Malta for the said purpose and within the terms of the Data Protection Act [Chapter 440, Laws of Malta].

I WISH TO DONATE MY BODY AFTER MY DEATH. I UNDERSTAND THAT IT MAY BE USED FOR:

- ANATOMICAL EXAMINATION
- EDUCATION OR TRAINING RELATING TO HUMAN HEALTH
- RESEARCH IN CONNECTION WITH DISORDERS, OR THE FUNCTIONING, OF THE HUMAN BODY

**Please tick as appropriate:**

- 1. I do not place any restrictions on the length of time that my body or body parts may be retained (if you tick this box, go straight to option 3, if not proceed to option 2).
- 2. My body can be retained for a maximum of 3 years only (please select either a. or b.)
  - a. Parts of my body may be retained for longer than 3 years.
  - OR
  - b. No part of my body may be kept for more than 3 years.
- 3. I consent to the use of imaging of my body or body parts. I understand that I will not be identifiable in these images which may include, but are not limited to, photographs, scans and videos, and that they will be used for:
  - Education or training relating to human health
  - Research in connection with disorders, or the functioning, of the human body
- 4. I have read and understood the contents of the attached "Information for Donors" which forms an integral part of this bequeathal form.
- 5. Whilst I authorise the University of Malta to disclose these my express wishes to competent authorities who need to know for the efficient carrying out of my wishes, I undertake to include my consent as expressed in this bequeathal form also in my will, albeit this declaration should suffice as independent proof of my express wishes to donate my body for the above described purposes.
- 6. I understand that, for various reasons, the University of Malta may **NOT** be able to accept my bequeathal. Reasons for not accepting my body donation include: having a weight of over 120kg at the time of death, being infected by a contagious serious infection at the time of death, undergoing an autopsy for forensic investigation and other exceptional circumstances which will be dealt with individually by consultation with the current Head of Department of Anatomy at the University of Malta.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part B: Witness declaration (signature of next-of-kin)**

I confirm that I have witnessed: \_\_\_\_\_ (insert name of donor)  
completing PART A of this form.

Surname/family name: \_\_\_\_\_ Forename(s): \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Relationship to donor: \_\_\_\_\_

Identity card / Passport number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_