॥वसुधैव कुटुम्बकम्॥

SYMBIOSIS MEDICAL COLLEGE FOR WOMEN (SMCW)

A Constituent of Symbiosis International (Deemed University)

(Established under section 3 of the UGC Act, 1956)

Re-accredited by NAAC with 'A' grade

Founder: Prof.Dr. S. B. Mujumdar, M. Sc., Ph. D. (Awarded Padma Bhushan and Padma Shri by President of India)

DEPARTMENT OF ANATOMY

e-mail: vaishaly.bharambe@smcw.siu.edu.in

Dr. Vaishaly Bharambe:- 9822910845
Dr. Vijayakumar:- 9940695046
Telephone No:- 020-61930000

BODY DONATION - REGISTRATION FORM

Reg No	

Name:_____

Address:_____

Age:_____years

Gender: _____

Phone: _____

Aadhaar card no:_____Date:…/……./20…..

To,
Professor & Head,
Department of Anatomy,
Symbiosis Medical College for Women,
Lavale, Pune.

Dear Sir / Madam,

I do hereby express my wish that, after my death, my body be donated at Symbiosis Medical College, Lavale, Pune, for the purpose of study and /or research work.

I do hereby make it clear that, my desire of donating the body has been expressed voluntary, without any undue pressure, force, influence or coercion. I have expressed desire by my own, purely out of social responsibility.

I have taken this decision of donating the body out of my own will and wishes and without any pressure or persuasions from any corner and I am physically and mentally fit and of sound mind to execute this my last will and testaments.

I request you to kindly register my name for the same. I expect that the person / people lawfully in-charge of my body after my death shall respect my wish and would try to execute by last will of donating my body after my death.

I have fully understood the rules and regulations of the Symbiosis Medical College for Women in respect of body donation.

Yours sincerely,

_____

_____

(Donor's signature and full name)

BODY DONATION - NO OBJECTION FROM CLOSE RELATIVES *

We, the undersigned, have no objection to donate the body of Shri / Smt. _____aged_____years, after his / her death for educational and / or research purpose to Symbiosis Medical College for Women, Lavale, Pune, as per his/her desire.

S. No	Name and address	Relation & Age	Mobile number	Signature
1.				
2.				
3.				

(please submit ID and address proof of the donor and the signatory relatives)

Head of Department

Department of Anatomy

The above form should be posted at the following address.

(To, Department of Anatomy, Building No 4, Symbiosis Medical College for Women, Lavale, Pune – 412115)