

DISPOSITION OF ORGANS RETAINED FOR EXTENDED EXAMINATION

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. NAME OF DECEASED	2. RANK OF DECEASED	3. LAST FOUR OF SSN
4. TYPED/PRINTED NAME OF PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD)		5. RELATIONSHIP

6.

I, the undersigned, understand that the _____ has/have been retained
(Specify organs retained)

by the Armed Forces Medical Examiner System for the purpose of extended examination to determine the cause and manner of death. This extended examination may take up to six months.

Armed Forces Medical Examiner System understands that the retention of organs can be a troubling and confusing issue. Please contact us at (301) 319-0000 at any time, day or night, if you have any questions regarding this extended examination or this form. After the examination is complete, you will receive a follow-up letter from the Armed Forces Medical Examiner System confirming your selection of disposition of the retained organ(s).

Upon completion of the extended examination, I elect the following option by placing my initials next to the option of my choice:

_____ **Do not notify me.** I authorize the Armed Forces Medical Examiner System to make proper disposition.
Initials

_____ **Notify me** when examination is complete and give me the opportunity to decide the disposition of the above-mentioned retained organ(s).
Initials

CONTACT TELEPHONE: 301-319-0000 - ARMED FORCES MEDICAL EXAMINER Main Office
24 hours a day, 7 days a week

AUTHORIZATION OF PADD AND WITNESS SIGNATURE

7. TYPED OR PRINTED NAME OF PADD	8. SIGNATURE OF PADD	9. DATE
10. TYPED OR PRINTED NAME OF WITNESS	11. SIGNATURE OF WITNESS	12. DATE