PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey
DEPARTMENT OF HEALTH
OFFICE OF THE CHIEF STATE MEDICAL EXAMINER
120 South Stockton Street
P.O. Box 360
Trenton, NJ 08625-0360
TELEPHONE (609) 376-0557 FAX (609) 633-8312
www.nj.gov/health

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

ANDREW L. FALZON, MD
Chief State Medical Examiner

DECEDENT TRANSFER AUTHORIZATION FORM

1. DECEDENT INFORMATION:

Name: ________________________________ Date of Birth: _______________
MR/ME #: _______________ EDRS#: ____________________
Sex: _____ Race: ______
Home Address/ Nursing Home of Residence: _____________________________________
Date of Death: _________________
Communicable disease: Yes___ No: ___ If yes, please attach DOH Communicable Disease Alert Form

2. NEXT OF KIN ("NOK") CONTACT INFORMATION:

Name: ______________________ Relationship to the Deceased: __________________
Telephone #: _________________ Address: __________________________________
NOK Informed of Transfer: Yes ____ No ____
If Yes, informed by: Phone ____ Voicemail ____ Other (Specify)_______

3. TRANSFERRING FACILITY REPRESENTATIVE INFORMATION:

Name of representative: ______________________ Title: _______________________
Facility: _____________________ Signature: ___________________
Telephone #: _________________ E-mail: ______________________
Facility Address: ____
Death Certificate Filed by Facility: Yes ____ No ____

4. DECEDENT TRANSPORTED TO STORAGE FACILITY BY:

Name: _______________________ Transportation Company/Facility: ________________
Signature: ____________________ Date/Time: _____________________

5. STORAGE FACILITY RECEIVING BODY:

North: _____ Central: _____ South: _____
Name: ______________________ Title: __________________________
Signature: ___________________ Date/Time: _____________________
Seal#: _______________
Trailer#: _____________ Rack#: ____________ Row#: ____________

6. DECEDENT RECEIPT WITNESSED BY:

Name: ______________________ Title: _______________
Signature: ___________________ Date/Time: __________
(The witness who signs Section 6 cannot be the same individual that signs Section 5 above.)

By signing this form above, the Transferring Facility has agreed that the following provisions are the sole responsibility of the Transferring Facility, and agreed that the Department of Health and the Office of the Chief State Medical Examiner have no responsibility regarding the following:

1. *Certification of death for death certificate*
2. *Transportation of the deceased to the storage facility*
3. *Proper identification of the deceased prior to transfer of body.*
4. *The removal and cataloguing of all property of value of the deceased prior to transferring the body*
5. *Unless NOK makes arrangements, final disposition of the deceased*