



Date (mm-dd-yyyy)

I understand that by signing below Mayo Clinic will dispose of the remains by cremation and that there will be no ashes or other remnants available to me for burial. I wish to leave the remains with Mayo Clinic to be disposed by mass cremation in accord with Mayo Clinic practices. The ashes will be placed in a designated grave site at a local cemetery in Rochester, Minnesota.

Signatures

Parent Name(s) (Last, First Middle)

Parent Signature(s)



Witness Name (Last, First Middle)

Witness Signature

