



## *Tri-State Regional Crematory*

*621 North Second Avenue*

*Evansville, IN 47710*

*Phone: (812) 425-8135*

*Fax: (812) 426-6514*



### **Cremation Authorization**

#### **Tri-State Regional Crematory Requirements for Cremation**

- ❖ A copy of the completed certificate of death is required prior to the cremation.
- ❖ Authorizing Agent(s) have received and understand the document “Tri-State Regional Crematory Policies, Procedures and Requirements.”
- ❖ All required legal, civil and medical permits and authorizations have been issued by the proper authorities.
- ❖ All necessary authorizations have been obtained and no objections have been raised.
- ❖ Any viewing, funeral service or ceremony requiring the body be present has been completed.
- ❖ The required waiting period between time of death and time of cremation (as required of the state where the death occurred) has elapsed.

Name of deceased: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Place of Death: City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Date of Death: \_\_\_\_\_ Time of Death: \_\_\_\_\_ AM/PM

TRI-STATE REGIONAL CREMATORY  
Cremation Authorization Form

Regarding: \_\_\_\_\_ (Hereinafter referred to as “decedent”)

The person(s) legally entitled to order the cremation is/are the authorizing agent(s). In the event there exists an individual having superior right to execute this Form, the Authorizing Agent certifies that all reasonable attempts have been made to contact such person, but has not been able to make contact, and believes that such person would not object to cremation.

Relationship of the authorizing agent to the decedent (*check one that applies*):

- |   |  |
|---|--|
| <input type="checkbox"/> The surviving spouse;              | <input type="checkbox"/> The surviving adult sibling;        |
| <input type="checkbox"/> The surviving adult children;      | <input type="checkbox"/> A next closest adult relative; or   |
| <input type="checkbox"/> The surviving parents;             | <input type="checkbox"/> In the absence of any of the above, |
| <input type="checkbox"/> The surviving adult grandchildren; | by order of _____  |

**I (we), the undersigned (hereinafter referred to as the “Authorizing Agent”) authorize the Tri-State Regional Crematory, in accordance with its Rules and Regulations as well as any applicable state and/or local rules and regulations, to cremation the human remains (decedent) identified by the Authorizing Agent(s), and to arrange for the delivery of the cremated remains as set forth in this document.**

Name of Funeral Home: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Funeral Director in Charge: \_\_\_\_\_

A visitation, funeral service or ceremony requiring the body be present (*circle one*) **WILL / WILL NOT** take place.

This \_\_\_\_\_ will take place on \_\_\_\_\_ at \_\_\_\_\_  
*(Type of Gathering) (Date) (Place)*

The cause of death (*circle one*) **WAS / WAS NOT** due to infectious disease.  
If yes, describe \_\_\_\_\_

**I (we) understand that if I (we) fail to notify Tri-State Regional Crematory of a death due to infectious disease that I (we) will be liable for any harm to Tri-State Regional Crematory personnel arising from such a disease.**

Has the deceased ever been treated with therapeutic radionuclotides using radioactive Strontium-89 or any other treatment that would result in residual radioactive material remaining as part of the decedent’s remains? (In most cases, human remains having received such treatment cannot be accepted for cremation.)

(*circle one*) **YES / NO** Date of last treatment: \_\_\_\_\_

I (we) further state that the decedent’s remains (*circle one*) **DOES / DOES NOT** include a heart pacemaker, radiation producing implant device or any other device that could be explosive. If such a device(s) has been implanted in the decedent, I (we) have instructed the funeral director or others to remove the said devices before the delivery of the decedent to Tri-State Regional Crematory for cremation, and attest that said devices have been removed. I (we) understand that failure to remove such devices may be hazardous to Tri-State Regional Crematory personnel and/or damaging to Tri-State Regional Crematory equipment and that I (we) will be liable for any such occurrence.

**I (we) have received and reviewed the document entitled “Tri-State Regional Crematory Policies, Procedures and Requirements” and hereby authorize the Tri-State Regional Crematory to perform the cremation in accordance with those rules and regulations.**

Initials of all Authorizing Agent(s): \_\_\_\_\_

Signature of person(s) identifying remains: \_\_\_\_\_

**Limitation of Liability**

As the Authorizing Agent(s), I (we) hereby agree to indemnify, defend and hold harmless Tri-State Regional Crematory, its officers, agents and employees of and from any and all claims, demands, causes or causes of action, and suits of every kind, nature and description, in law or equity, including any legal fees, costs and expenses of litigation, arising as a result of, based upon or connected with this authorization, including the failure of the Authorizing Agent(s) to properly identify the human remains transported to Tri-State Regional Crematory, mistakes in processing and shipping of the decedent’s cremated remains resulting from the authorization, the failure of the Authorizing Agent(s) or their designees to take possession of or make proper arrangement for the final disposition of the cremated remains, any damages from harmful or explodable implants, claims brought by any other persons claiming the right to control final disposition of the decedent or the decedent’s cremated remains, or any other action performed by Tri-State Regional Crematory, its officers, agents or employees pursuant to this authorization, excepting only willful negligence on the part of Tri-State Regional Crematory.

**Signature(s) of Authorizing Agent(s)**

By the execution of this cremation authorization form, as Authorizing Agent(s), the undersigned warrant that all statements contained in this form are true and correct, that these statements were made to induce the Tri-State Regional Crematory to cremate the human remains of the decedent, and that the undersigned have read and understand the document “Tri-State Regional Crematory Policies, Procedures and Requirements,” the provisions contained on this form, and that each individual has initialed all applicable portions.

Executed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Relationship to Decedent: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Relationship to Decedent: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Relationship to Decedent: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Representation of Funeral Director**

By executing this authorization form as a licensed funeral director and agent of the funeral home indicated herein, which is serving as agent for the Authorizing Agent(s), I warrant to the best of my knowledge the following:

- That funeral home named herein was responsible for making arrangements with the Authorizing Agent(s) for the cremation of the decedent and that we reviewed this authorization form with the Authorizing Agent(s) and witnessed their signature(s).
- That the representations contained herein concerning the decedent’s cause of death and regarding infectious or contagious disease are true.
- That the representations contained herein concerning a pacemaker and/or any other material or implant or treatments that may be potentially hazardous are true.
- That any personal items/valuables not to be cremated with the decedent have been removed from the cremation container.
- That the funeral director in charge has complied with all State rules and regulations governing cremation, for the State in which the death occurred.
- That the Tri-State Regional Crematory has permission to proceed with the cremation process.

\_\_\_\_\_  
Signature of Licensed Funeral Director

\_\_\_\_\_  
Funeral Home

Cremation Container: \_\_\_\_\_

Urn/Container: \_\_\_\_\_

Cremated remains will be:

Picked up at the Crematory Office by: \_\_\_\_\_

Delivered to the U.S. Postal Service for shipment by Registered, Return Receipt mail to:

Name: \_\_\_\_\_ Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_