

GENESIS FUNERAL HOME & \$495 CREMATION CENTER INC.
5749 PEMBROKE RD. HOLLYWOOD, FL. 33023
OFFICE: (954) 962-3017 FAX: (954) 962-3019 TOLLFREE: (877) 962-3017

ARRANGEMENT WORKSHEET

Decedent Name: _____
First Middle Last

Sex: Male Female **Date of Birth:** ____/____/____ **Age:** _____

Date of Death: ____/____/____ **SS #** ____-____-____ **Veteran:** Yes No

Place of Birth: State _____ Country _____ City _____

Place of Death: _____
Street Address Apt #

City State Zip County

Home Address _____
Street Address Apt #

City State Zip County

Marital Status: S M D W **Surviving Spouse Name**
(If wife maiden name) _____

Occupation: _____ **Industry:** _____
(Last or Usual)

Race: _____ **If Hispanic or Haitian**
Provide Origin: _____

Fathers full Name: _____ **Mothers full Name:**
(If married maiden name) _____

Education : Grades 8 or Less Grades 9-12 No Diploma GED or H.S. Diploma Some College No Degree AS BA MA DOC UNKNOWN

Legal Next of Kin/ Informant Name: _____

Street Address Apt #

City State Zip County

Relationship: _____ **Phone:** _____ **Email:** _____

Authorized Contact Name : _____ **Phone:** _____

*The cremation process may take from 10-14 days (excluding weekends, holidays, shipping or medical delays).
Please review this form carefully, the information provided will be used for the completion of the death certificate,
Charges will apply for corrections needed as a result of incorrect or illegible information provided.*

Signature: _____ **Date:** _____

GENESIS FUNERAL HOME

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Email: genesisfuneralhome@gmail.com

Release of Remains Authorization

To Whom It May Concern At: _____
(Name of the Hospital or Residence Address)

This Is Your Authority To Release The Remains of:

(Deceased Name)

To Genesis Funeral Home & \$495 Cremation Center Inc. To Care For and Prepare For Burial and/or Other Disposition.

X _____
Printed Name of Person Granting Authorization

Relationship

X _____
Signature of Person Granting Authorization

Date

Witness Signature

Date

Type of Service Selected: _____

Information For Medical Examiner Department Record

Race: _____

Sex: _____

Date Of Birth: _____

Age: _____

Office us only:

Fax To: Medical Examiner

Hospital

Hospice

Other

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CREMATION AUTHORIZATION

Permit Number: _____ **Me No.:** _____ **Date:** _____

The undersigned hereby request and authorize in accordance with and subject to our rules and regulations as well as those of the State of Florida to cremate the remains of: _____
(Name of Deceased)

age _____, who died at _____, on the _____
(Place of Death)

_____ day of _____, 20____, at _____ am/pm.

LEGALLY AUTHORIZED AGENT

The undersigned represents that they have the right to make such authorization and agrees to hold Genesis Funeral Home & \$495 Cremation Center Inc., its Funeral Director, Agents and Sub Contractors harmless from any liability to or as consequence of said authorization. The undersigned is aware that the Medical Examiner's approval must be obtained prior to cremation taking place, and that a 48-hour waiting period is required before the cremation can take place. Permission is also granted for the removal of pacemaker if one is present in the deceased. The undersigned acknowledges that they are aware that should the cremains remain unclaimed in excess of 120 days from the day of cremation, the Funeral Home according to Florida Statutes; Section 470.0255 can dispose of the cremains in a manner described by the above mentioned statute. Undersigned understand that Florida law requires the Crematory to receive written authorization for cremation from a legally authorized person and certify that they qualify as such in the manner noted below. Furthermore, they represent that the Decedent did not give directions that his or her human remains not be cremated, nor are they aware of any objections to the cremation of the Decedent's human remains by others in the same class of person listed below as the undersigned or of any person in a higher priority class.

(CHECK APPLICABLE BOX) I HAVE FULL AUTHORITY TO ACT AS AUTHORIZING AGENT AS:

- Undersigned is making this authorization for himself or herself.
- Surviving spouse of the Decedent at the time of death and I am entitled to serve as authorized agent
- Surviving adult child of the Decedent age 18 years or older, I have notified or attempted in good faith to notify any other surviving adult children and I am entitled to serve as authorized agent there being no surviving spouse.
- Surviving parent of the Decedent I have notified or attempted in good faith to notify the other parent and I am entitled to serve as authorized agent with there being no surviving spouse or adult children.
- Surviving sibling of the Decedent age 18 years or older, I have notified or attempted in good faith to notify any other surviving siblings and I am entitled to serve as authorized agent there being no surviving spouse, children, or parents.
- Surviving next of kin of closest degree to the Decedent as _____ and I am entitled to serve as authorized agent there being no surviving spouse, children, parents or siblings.
- Court appointed legal representative or guardian, health surrogate of the decedent of at the time of death who can serve as the legally authorized person since either no family exists or is available (attached is a copy of the Court Appointment Documents or Will).
- Friend of Decedent or other person willing to assume the responsibility as the authorized person there being no surviving persons as listed above (attached is a copy of the Due Diligence FS 470.002(18))

CONFIRMATION OF IDENTIFICATION WITHOUT VIEWING

Part I (To be completed by funeral home representative)

Name of Deceased: _____

Reason visual identification was not performed: _____

Describe alternative methods used to confirm identification: *(e.g. Photographs, scars or tattoos)*

Name and relationship of person providing identifying information: _____

Name of funeral home representative confirming identification: _____

Part II (To be completed by legal representative)

I _____, the undersigned having declined to make identification through actual viewing of the remains of the deceased, warrant that all representations and statements contained in this form are true and correct, I hereby agree to indemnify Genesis Funeral Home And \$495 Cremation Center Inc., its officers, directors, shareholders, affiliates, agents, employees and successors and assignees harmless from any and all claims, liabilities, losses, suits, cost or expenses or cause of action (including attorneys fees and all expenses of litigation) bought by any person, firm or corporation or the personal representative thereof, relating to or arising out of such failure to identify or resulting from its reliance on or performance consistent with such directions, representations, authorizations and agreements.

This form must be signed in the presence of the funeral home employee or in the presence of a notary public

Printed Name	Signature	Relationship	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Funeral Home Representative Name **Signature** **Date**

Subscribed and Sworn Before Me _____ 20_____ <input type="checkbox"/> Personally known or <input type="checkbox"/> Produced Identification ID Produced _____	Printed Name of Notary _____ Signature of Notary _____ Stamp _____
My Commission Expires _____	



GENESIS FUNERAL HOME
5749 Pembroke Rd. Hollywood Fl 33023
Phone (954) 962-3017 Fax (954) 962-3019
Email: genesisfuneralhome@gmail.com

RELEASE OF CREMATED REMAINS AND DEATH CERTIFICATE(S)

OPTION A:

I _____ will personally be picking up the cremated remains and death certificates of _____ From *Genesis Funeral Home & \$495 Cremation Center Inc.*
Decedent Name

The undersigned acknowledges, that the cremation process may take from 10-14 days; (excluding weekends, holidays, medical delays or shipping) and that cremated remains which remain unclaimed in excess of 120 days from the date of cremation, may be disposed of by the Funeral Home according to Florida Statues; Section 470.0255.

Signature _____ Relationship _____ Date: _____

OPTION B:

I _____ authorize *Genesis Funeral Home* to release the cremated remains and death certificates of _____ to _____
Decedent Name Person Receiving Remains/DC's

Phone _____

The undersigned acknowledges, that the cremation process may take from 10-14 days; (excluding weekends, holidays, medical delays or shipping) and that cremated remains which remain unclaimed in excess of 120 days from the date of cremation, may be disposed of by the Funeral Home according to Florida Statues; Section 470.0255.

Signature _____ Relationship _____ Date: _____

OPTION C:

I _____ hereby request and grant permission to *Genesis Funeral Home* to ship the cremated remains and death certificates of _____ to: _____
Decedent Name

Name of Recipient _____ Phone _____

Address _____

The undersigned acknowledges, that the cremation process may take from 10-14 days; (excluding weekends, holidays, medical delays or shipping), that cremated remains which remain unclaimed in excess of 120 days from the date of cremation, may be disposed of by the Funeral Home according to Florida Statues; Section 470.0255. The undersigned also acknowledges and agrees that following the proper delivery of the cremated remains to the United States Postal Service, Genesis Funeral Home & \$495 Cremation Center Inc. is released of further responsibly and/or held harmless of any liability resulting the late delivery, loss or damage of cremated remains by the United States Postal Service.

Signature _____ Relationship _____ Date: _____

OPTION D:

I _____ Give my permission and authorize *Genesis Funeral Home* to

Dispose (Sea Scatter) the cremated remains of _____
Decedent Name

Signature _____ Relationship _____ Date: _____

Shipping By U.S. Postal Service (Express Mail USA ONLY)

GENESIS FUNERAL HOME
5749 Pembroke Rd. Hollywood Fl 33023
Phone (954) 962-3017 Fax (954) 962-3019
Credit Card Authorization Form
All information will remain confidential

Cardholder Information:

Cardholder Name: _____
Card Billing Address: _____
City State, Zip Code _____

Credit Card Information:

Credit Card Type: **Visa** **MasterCard** **Discover** **Am Ex**

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (located on the back of the credit card): _____

Please Review or add Services Selected

- | | | |
|-------------------------------------|--|-----------------------|
| <input checked="" type="checkbox"/> | Direct Cremation with Private Viewing (1-4) Persons | \$695.00 |
| <input checked="" type="checkbox"/> | Removal & Transportation (Broward or Dade \$125) (Palm Beach \$150) | \$ |
| <input checked="" type="checkbox"/> | County Fee (Add: Broward or Dade \$65.00) (Palm Beach \$50.00) | \$ |
| <input checked="" type="checkbox"/> | Death Certificates (Add \$15.00ea) # _____ | \$ |
| <input type="checkbox"/> | Basic Urn W/ Inscription (\$40.00ea) # _____ | \$ |
| <input type="checkbox"/> | Shipping Cremated Remains (Optional Add \$95) | \$ |
| <input checked="" type="checkbox"/> | Credit Card Processing Fee | \$ <u>3.95</u> |
| | Total (USD) Amount to Be Billed To Card: | \$ |

Cardholder Statement:

I _____ authorize **Genesis Funeral Home** to charge the agreed amount listed above to my credit card for the selected funeral services rendered to _____. I agree to pay for the purchase of these services in accordance with the issuing bank cardholder agreement.

Cardholder – Please Print Name, Sign and Date Below:

Printed Name of the Cardholder Granting Authorization

Relationship to Decedent

Signature of Cardholder Granting Authorization

Date