MEDICAL EXAMINER DEPARTMENT
PUBLIC INTERMENT PROGRAM (PIP)
(305) 545-2409 Fax

AUTHORIZATION OF CREMATION AND DISPOSITION

NAME OF DECEASED: _____ **DATE:** _____
(MONTH/DAY/YEAR)

_____ _____
PRINT NAME OF PERSON AUTHORIZING CREMATION **SIGNATURE**

_____
RELATIONSHIP TO DECEDENT

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (HOME/WORK) _____ **(CELL)** _____

Witness: _____ _____
Print Name **Signature**

I/We, the oversigned, hereby request, authorize and direct Miami-Dade County to cremate the above named remains in accordance with, and subject to the Florida Statutes governing Crematories/Direct Disposers.

I/We understand that Florida Law authorizes the disposal of unclaimed cremains after 120 days from the date of cremation.

I/We agree to indemnify, release and hold Miami-Dade County, its agents and employees harmless from any and all loss, damages, liability or causes of action (including attorney's fees and expenses of litigation) in connection with the cremation and disposition of the cremated remains of the deceased, as authorized below:

Cremains Disposition: ☐ **Authorized person will claim ashes** ☐ **Scatter as Appropriate**

FOR PIP OFFICE USE

PIP CASE NUMBER: _____

Proof of Government Assistance: ☐ **YES** ☐ **NO**

Charge: _____

Method of Payment: Cash

Print Form