

Application for individual cremation of foetal remains

*I/We _____

Of (address) _____

Being the parent(s) make application for cremation of the foetal remains

of: (MOTHER'S NAME) _____

delivered on: _____ Hospital Unit No: _____

at: (ADDRESS) _____ at less than 24 weeks gestation.

***I/We certify that *I/We have no reason to suspect that the duration of the pregnancy was shortened by any unlawful act and know of no reason why any further enquiry or examination should be made. (*delete as appropriate)**

Name: _____

Signature(s): _____ Date: _____

Name: _____

Signature(s): _____ Date: _____

***I/We understand Wealden Crematorium adheres to their Policy Statement with regard to baby and infant cremation and as such, best practice is employed to maximise the recovery of cremated remains. Therefore, where remains are recovered, *I/we would like to have those remains – Please select one of the options below:**

1. Strown in the Garden of Remembrance at Wealden Crematorium in our presence (witnessed).

2. Strown in the Garden of Remembrance at Wealden Crematorium without me/us being present (unwitnessed).

3. Have them collected by: _____
(Please specify by either Funeral Director, Parent(s) or other named person – please supply their full name and address)

Signed: _____ Date: _____

NB This application must be accompanied by a Certificate of Medical Practitioner or Midwife in Respect of Foetal Remains