Dublin Cemeteries Trust Est. 1828

FORM A

Funeral Directors **Confirmatory Form**

Part 1: Service Details

Dublin Cemeteries Trust will not accept cremation forms from other crematoria

Glasnevin Crematorium ☐ **Newlands Cross Crematorium** ☐ **Dardistown Crematorium** ☐

Please note that the cremation may take place in any of the Dublin Cemeteries Trust Crematoria

Cremation to take place: Day: Date: Time:

Extended Service ☐ Music: Supplied on USB ☐ Smartphone ☐ Laptop/Tablet ☐ Songlist Emailed ☐

Webstream Y ☐ N ☐

Any other requirements:

Cremation No: Date:

Funeral Director: Telephone No:

Address:

Email:

Disposal: Private ☐ Columbarium Wall ☐ Garden of Remembrance ☐ Other ☐

If Private Urn Choice: Standard Urn ☐ Casket ☐ Brass urn ☐ Decorative metal urn ☐ Own urn ☐

Note: If the ashes are being buried or scattered outside of any of Dublin Cemeteries Trust cemeteries, please indicate location

For cremations from outside the Republic of Ireland the following forms are required ONLY :
Form A, Form B, Coroners Certification for the removal of the body, and Death Certificate from the relevant jurisdiction
The Coroner for Dublin City and County MUST be informed and a Coroners Form D signed.

Part 2: Deceased Details

Name:

Address:

Date death:

Place of death:

The dimensions of the coffin in centimetres are: Length: Width: Depth:

Part 3: Coffin Details

Please note that handles on coffins for cremation serve no useful purpose and are unnecessary, if used they must be of combustible materials. If metal they must be removed before cremation.

Note: If coffin dimensions are greater than Length 7½ ft (228cms) Width 36" (91.44cms) Height 24" (61cms)
Please contact the crematorium to see if the coffin can be cremated.

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Has the deceased been fitted with any of the following battery powered and other implants that could cause problems during cremation: **Please indicate either YES Or NO for each device listed (do not leave the box blank).**

a)	Pacemaker	Y ☐ N ☐
b)	Implantable Cardioverter Defibrillators (ICDs)	Y ☐ N ☐
c)	Cardiac resynchronization therapy devices (CRTDs)	Y ☐ N ☐
d)	Implantable loop recorders	Y ☐ N ☐
e)	Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs)	Y ☐ N ☐
f)	Implantable drug pumps including intrathecal pumps	Y ☐ N ☐
g)	Neurostimulators (including for pain & Functional Electrical Stimulation) Bone growth stimulators	Y ☐ N ☐
h)	Hydrocephalus programmable shunts	Y ☐ N ☐
i)	Fixion nails	Y ☐ N ☐
j)	Any other battery powered or pressurised implant	Y ☐ N ☐
k)	Radioactive implants	Y ☐ N ☐
l)	Radiopharmaceutical treatment (via injection)	Y ☐ N ☐
	Other prosthesis	Y ☐ N ☐

Please state

If the answer to Part 3 above is in the affirmative they must be removed

Please state by whom?

When: Date **Time**

Cardboard coffins or coffins with pitch inside are not accepted for cremation.

Part 5: Declaration

As a data-processor acting on our behalf, once the cremation has been authorised by Dublin Cemeteries Crematoria and the cremation service completed, forms must not be retained and must be destroyed.

I hereby certify that I have complied with all the regulations laid down by Glasnevin Crematorium Ltd., and adhere to the above.

Name of Funeral Director:

Signature of Funeral Director:

Print Name:

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FORM B

Application For **Cremation**

PART 1: Applicant Details

Please note the the cremation may take place in any of the Dublin Cemeteries Trust's Crematoria.

ALL QUESTIONS MUST BE ANSWERED

PURSUANT TO THE BYE LAWS MADE BY GLASNEVIN CREMATORIUM LIMITED

This form must be completed and signed by executor of the deceased or nearest surviving relative and witnessed by a third party. Applicant MUST be 16 years of age or older at the time of death to apply for cremation of an adult or child. There is no age restriction if the person making the applicant is the parent of the child who has died.

PLEASE PRINT IN BLACK PEN ONLY

Name:

Address:

Apply to Glasnevin Crematorium Limited to undertake the cremation of

1. Are you an executor of the deceased? Y ☐ N ☐
2. If answer to 1 is 'No'

   (a) Has the nearest surviving relative been informed Y ☐ N ☐

   Relatives Name Relationship to deceased

   (b) Your relationship to the deceased.

   (c) The reason why the application is made by you and not by an executor or nearest surviving relative.

PART 2: Deceased Details

Name:

Address:

Date of death: Age: Sex: Religion:

Occupation:

Status: Married / Civil Partner ☐ Widow / Widower/Surviving Civil Partner ☐ Single ☐

1. Do you know or have any reason to suspect that the death of the person who has died was violent or unnatural or was referred to a Coroner? Y ☐ N ☐
2. Do you consider that there should be any further examination of the remains of the person who has died ? Y ☐ N ☐

3. Has the deceased been fitted with any of the following battery powered and other implants that could cause problems during cremation: **Please indicate either YES Or NO for each device listed (do not leave the box blank).**

a)	Pacemakers	Y ☐ N ☐
b)	Implantable Cardioverter Defibrillators (ICDs)	Y ☐ N ☐
c)	Cardiac resynchronization therapy devices (CRTDs)	Y ☐ N ☐
d)	Implantable loop recorders	Y ☐ N ☐
e)	Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs)	Y ☐ N ☐
f)	Implantable drug pumps including intrathecal pumps	Y ☐ N ☐
g)	Neurostimulators (including for pain & Functional Electrical Stimulation) Bone growth stimulators	Y ☐ N ☐
h)	Hydrocephalus programmable shunts	Y ☐ N ☐
i)	Fixion nails	Y ☐ N ☐
j)	Any other battery powered or pressurised implant	Y ☐ N ☐
k)	Radioactive implants	Y ☐ N ☐
l)	Radiopharmaceutical treatment (via injection)	Y ☐ N ☐
	Other prosthesis	Y ☐ N ☐

Please state

If the answer to the above is in the affirmative they must be removed. Please state by whom?

NOTE: CREMATION MAY BE REFUSED IF CERTAIN PROSTHESIS ARE NOT REMOVED.

PART 3: Disposal Details

This section is used to record what is to happen to the ashes after cremation. Options will vary at each crematorium. Please discuss with the crematorium or alternatively speak to your funeral director.

☐ **A. I will collect the ashes from the crematorium.**

I understand that I must collect the ashes from the crematorium within **4 weeks,** and that photo ID will need to be presented at the time of collection.

Ashes of the deceased are available for collection 3/4 days after the cremations service

If the ashes are being buried or scattered outside of any of Glasnevin Trusts cemeteries, please indicate location

☐ **B. I nominated my representative to collect on my behalf.**

Name

Address

☐ **C. I instruct the crematorium to inter the cremated remains in:**

Columbarium Wall ☐ Garden of Remembrance ☐

Family Grave in any of the Dublin Cemeteries Trust Cemeteries ☐

Family Cremation plot (Dardistown only) ☐ Water URN ☐

If option C the relevant crematorium will contact you to arrange attendance, inscription and to discuss service options. Please indicate that you consent to this. Y ☐ N ☐

Name of person to be contacted

Phone Email

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Application For **Cremation**

PART 4: Inspection of Certificates

Please state if you would like to inspect the cremation medical certificate Form C given by the doctor or whether you would like to nominate someone else to do so instead and give a contact telephone number. Y ☐ N ☐

Person to be contacted. Name:

Contact Details :

PART 5: Applicant Declaration

I declare that to the best of my knowledge and belief the information given in this application is correct and no material particular has been omitted.

Date: (Signature of applicant)

NOTE: This Certificate should be returned to the funeral director to arrive no later than 3.00pm on the day prior to Cremation.

If you require further information please contact Mark O'Neill (Cremation Sales Manager) to assist you with all aspects of personalising the cremation service and memorialisation options.
Phone - 086 8393515 / Email - moneill@dctrust.ie

PART 6: Funeral Director Declaration

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date: (Signature of Witness)

Using Block Letters Please Print Witness Name

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FORM C

Medical **Certificate**

This form is issued by Glasnevin Crematorium Limited, Finglas Road, Dublin 11. Tel: (01) 882 6500.
www.dublincemeteriestrust.ie

This Certificate should reach the relevant office
NO LATER THAN 3.00PM ON THE DAY PRIOR TO THE CREMATION.

PURSUANT TO THE BYE LAWS MADE BY GLASNEVIN CREMATORIUM LIMITED

Completion of this form is mandatory. **All questions must be answered** to complete the certificate for the purposes of Cremation.

The doctor completing the certificate must see the body **before and after death**.

Must be **FULLY REGISTERED** on The Medical Register of Ireland i.e. **POST INTERN YEAR**

PART 1: STATEMENT OF TRUTH

PLEASE PRINT IN BLACK PEN ONLY

I certify that I am a registered medical practicioner.

I hereby certify that the answers given below are true and accurate to the best of my knowledge and belief.

Name (Block capitals) | Signature

Practice Address

Date | **REGISTERED NUMBER:**

Telephone No

PART 2: DETAILS OF THE DECEASED

I am informed that application is about to be made for the cremation of the remains of:-

Name of deceased

Deceased Address

PART 3: REPORT ON THE DECEASED

HAVING SEEN AND IDENTIFIED THE DECEASED BEFORE AND AFTER DEATH.

I give the following answers to the questions set out below:-

1. (a) Were you the regular attending doctor of the Deceased Y ☐ N ☐
   (b) If so, for how long?
2. (a) Did you attend the Deceased during his or her last illness Y ☐ N ☐
   (b) If so, for how long?
3. (a) When did you last see the deceased alive? Date
   (say how many days or hours before death) Days or Hours
4. (a) How soon after death did you see the deceased?
   (b) What examination did you make?
5. On what date and at what hour did he or she die? Date | Hour

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NOTE: If the death is not due to natural causes and has been referred to the coroner for investigation, this Form C need not be completed.

FORM C

Medical **Certificate** Continued

6 (a) Address where the deceased died

(b) Please indicate whether answer to 6 (a) above was: Own residence ☐ Hospital ☐ Nursing Home ☐

Other (please state)

7. (a) Are you a relative of the deceased? Y ☐ N ☐

(b) If yes, state relationship

8. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? Y ☐ N ☐

9. Cause of death and duration of last illness: (NO ABBREVIATIONS)

Disease or condition directly leading to death (a)

due to (or as a consequence of) (b)

Approximate interval between onset and death

Antecedent causes (c)

Morbid conditions, if any, due to (or as a consequence of)

Giving rise to the above

Cause, stating the underlying Condition last (d)

Approximate interval between onset and death

Other significant conditions contributing to the death

but not related to the disease or condition causing it

Approximate interval between onset and death

NOTE:IF DEATH IS NOT DUE TO NATURAL CAUSES, THE CORONER SHOULD BE NOTIFIED

10. (a) State how far the answer to the last question Is the result of your own observation

(b) If not your own observation, what was the Source of your information?

11. (a) Has a Post Mortem been carried out? Y ☐ N ☐

(b) If "YES" state by whom the examination was made

12. By whom was the deceased nursed during his or her last illness

(Give names and say whether professional nurse, Relatives etc. If the illness was a long one this question Should be answered with reference to The period of four weeks before the death)

13. Who were the persons present (if any) at the moment of death?

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NOTE: If the death is not due to natural causes and has been referred to the coroner for investigation, this Form C need not be completed.

FORM C

Medical **Certificate** Continued

14. In view of your knowledge of the deceased's habits and constitution, do you feel any doubt whatsoever as to the character of the disease or the cause of death stated in 9, over?

15. Have you any reason to suspect that the death of the person who has died was violent or unnatural? Y ☐ N ☐

16. Do you have any reason to suspect that the death occurred under or within 24 hours of anaesthetic or medial procedure, or admission to hospital. Y ☐ N ☐

17. Have you any reason whatever to suppose a further examination of the deceased to be desirable? Y ☐ N ☐

18. Has a coroner been informed or has there been any discussion with the coroner about the death? Y ☐ N ☐

Date and time of enquiry

If yes, please state coroners office that was contacted

State the outcome of the discussions

19. (a) Did you sign the Death Notification / Registration Form? Y ☐ N ☐

(b) If No, who has?

20. Has the deceased been fitted with any of the following battery powered and other implants that could cause problems during cremation: **Please indicate either YES Or NO for each device listed (do not leave the box blank).**

a) Pacemaker Y ☐ N ☐
b) Implantable Cardioverter Defibrillators (ICDs) Y ☐ N ☐
c) Cardiac resynchronization therapy devices (CRTDs) Y ☐ N ☐
d) Implantable loop recorders Y ☐ N ☐
e) Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs) Y ☐ N ☐
f) Implantable drug pumps including intrathecal pumps Y ☐ N ☐
g) Neurostimulators (including for pain & Functional Electrical Stimulation) Bone growth stimulators Y ☐ N ☐
h) Hydrocephalus programmable shunts Y ☐ N ☐
i) Fixion nails Y ☐ N ☐
j) Any other battery powered or pressurised implant Y ☐ N ☐
k) Radioactive implants Y ☐ N ☐
l) Radiopharmaceutical treatment (via injection) Y ☐ N ☐

Other prosthesis Y ☐ N ☐

Please state

If the answer to above is in the affirmative they must be removed

Please state by whom?

NOTE: CREMATION MAY BE REFUSED IF CERTAIN PROSTHESIS ARE NOT REMOVED.

FORM D

Dublin Cemeteries Trust Est. 1828

Coroners **Certificate** For Cremation

PLEASE PRINT IN BLACK PEN ONLY

I certify that I am satisfied that there are no circumstances likely to call for a further examination of the deceased.

PARTICULARS OF DECEASED PERSON

Full Names

Sex

Age

Date of death

Place of death

Please insert name here in block capitals

Signature

Coroner for the ____ of ____

Date

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FORM E

Authority To **Cremate**

PLEASE PRINT IN BLACK PEN ONLY

An application has been made for the cremation of the remains of

Cremation No:

Name:

Address:

Occupation or description:

And whereas I have satisfied myself that all the requirements laid down by Glasnevin Crematorium Limited have been complied with, that the cause of death has been definitely ascertained and that there only exists no reason for any further inquiry or examination.

I hereby authorise Glasnevin Crematorium Limited to cremate the said remains.

Medical Referee to Glasnevin Crematorium Limited

(Signature)

Date

Comment

FORM F

Dublin Cemeteries Trust Est. 1828

Disposal Of **Cremated** Remains

PLEASE PRINT IN BLACK PEN ONLY

Deceased Name:

Cremation service was held at: ☐ Glasnevin ☐ Newlands Cross ☐ Dardistown

Signed at the time of collection

I hereby acknowledge receipt of and accept full responsibility for the urn containing the cremated remains of from Glasnevin Crematorium Ltd.

If the ashes are being buried or scattered please indicate location

Name:

Signed:

Date:

Identification checked ☐ Document presented