



THE STATE  
of **ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**MOR**

FOR DIVISION USE ONLY

**Mortuary Science Program**

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## Embalmer Trainee Case Report

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure (AS 08.42.050). Please type or print. Case Reports with illegible writing will be returned.

12 AAC 50.200(d) requires six case reports of embalmings performed by a trainee during the previous quarter to be submitted to the division every three months of an embalmer trainee's apprenticeship.

### PART I Personal Information

Trainee Name:		Trainee Permit Number:	
Sponsor Name:		License number:	
Report for Quarter: (Select One)	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup>		
Quarter Begin Date:		Quarter End Date:	

### PART II Case Identification

Case Number:		Date of Embalming Operation:	
Time and Date Started:		Time and Date Completed:	

### PART III Identification of Deceased

Name of Deceased:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth:		Date of Death:	
Place of Death:			
Primary Cause of Death:			
Approx. Weight:		Approx. Height:	

## PART IV Pre-Embalming Condition of the Body

Check all that apply:

- Normal       Decomposing       External/Internal Wounds       Jaundice       Rigormortis  
 Mutilation       Purge       Tumor/Ulcer       Skin Slip       Odor  
 Discoloration       Gangrene       Tissue Gas       Surgery       Edematous/Dropsical  
 Autopsy Partial or Full (Describe): \_\_\_\_\_  
 Organ and/or Tissue Donor (Describe): \_\_\_\_\_

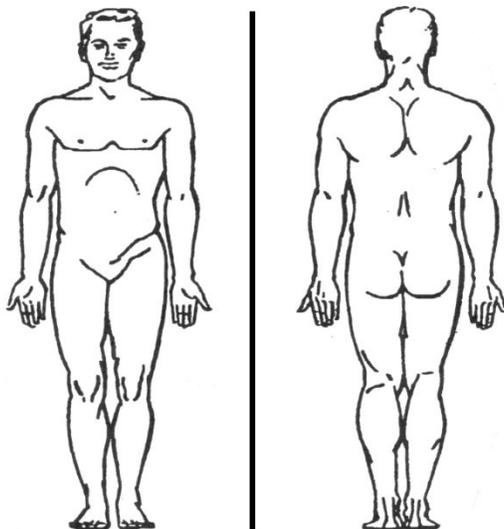
## PART V Embalming

<b>Time Between Death and Embalming:</b>			
<b>Body Refrigerated:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, location of refrigeration:</b>	
<b>Features Set:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Arteries Used for Injection:</b>		<b>Veins Used for Drainage:</b>	
<b>Method of Injection:</b>	<input type="checkbox"/> Machine <input type="checkbox"/> Gravity <input type="checkbox"/> Hand Pump		
<b>Fluid Used:</b> (Trade Name & Index)		<b>Amount of Fluid Used:</b>	
<b>Fluid Used:</b> (Trade Name & Index)		<b>Amount of Fluid Used:</b>	
<b>Fluid Used:</b> (Trade Name & Index)		<b>Amount of Fluid Used:</b>	
<b>Other Supplemental Chemicals or Fluid Used:</b>			
<b>Cavity Treatment Done:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Cavity Fluid Name:</b>		<b>Ounces Injected Undiluted:</b>	
<b>Viscera Treatment:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Suturing:</b> (Describe)	
<b>Instrument Disinfection:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Method of Disposal of Hazardous Materials:</b>	<input type="checkbox"/> Biohazard Bag <input type="checkbox"/> Sharps <input type="checkbox"/> Soiled Linen <input type="checkbox"/> Other: _____		
<b>Universal Precautions Used:</b>	<input type="checkbox"/> Gloves <input type="checkbox"/> Mask <input type="checkbox"/> Gown <input type="checkbox"/> Face/Eye Shield <input type="checkbox"/> Shoe Covering		
<b>Did any of the following occur during embalming?</b>			
<input type="checkbox"/> Clearing <input type="checkbox"/> Firming <input type="checkbox"/> Purge <input type="checkbox"/> Leakage <input type="checkbox"/> Distension of Face or Hands <input type="checkbox"/> Vascular Problems			

**PART V** Embalming (continued)

How were any problems encountered rectified? \_\_\_\_\_

*Indicate on chart all identifying scars, moles, birthmarks, tattoos, missing digits, and special body characteristics.*



Description of items marked on chart:

- |          |           |
|----------|-----------|
| 1. _____ | 2. _____  |
| 3. _____ | 4. _____  |
| 5. _____ | 6. _____  |
| 7. _____ | 8. _____  |
| 9. _____ | 10. _____ |

Condition of body at completion of embalming: \_\_\_\_\_

On second day: \_\_\_\_\_

At time of service: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## PART VI Restorative and Cosmetic Treatment, Dressing and Casketing of Remains

Write a brief explanation of each:

Describe Special Restorative Treatments: \_\_\_\_\_

\_\_\_\_\_

Describe Cosmetic Treatments: \_\_\_\_\_

\_\_\_\_\_

Cosmetics Used: \_\_\_\_\_

Hair Styling: \_\_\_\_\_

Clothing: \_\_\_\_\_

Jewelry/Other Items:  Remained on Deceased  Returned to Family

(List all jewelry items, wedding rings, watches, glasses, personal items, etc.): \_\_\_\_\_

\_\_\_\_\_

Describe Dressing of Remains: \_\_\_\_\_

\_\_\_\_\_

Other Treatment or Comments: \_\_\_\_\_

\_\_\_\_\_

Restorative and cosmetic treatment, dressing, and casketing by: \_\_\_\_\_

Assistant: \_\_\_\_\_

## PART VII Signatures

<b>Trainee Printed Name:</b>			
<b>Trainee Signature:</b>		<b>Date Signed:</b>	
<b>Supervisor Printed Name:</b>			
<b>Supervisor Signature:</b>		<b>Date Signed:</b>	