



Broward County  
**OFFICE OF MEDICAL EXAMINER AND TRAUMA SERVICES**  
**Authorization for Cremation and Disposition**

\_\_\_\_\_  
NAME OF DECEASED

\_\_\_\_\_  
DATE

I/We, the undersigned, hereby request, authorize and direct Broward County to cremate the above-named decedent's remains in accordance with and subject to Florida Statutes, and the rules and regulations set forth in the Florida Administrative Code, governing Crematories/Direct Disposers.

I/We understand that the cremains will be scattered at sea after 120 days from the date of cremation. I/We understand that I/We must request in writing the location of the final disposition, if so desired.

I/We agree to indemnify, release and hold Broward County, its officers, employees and agents harmless from any and all liability, including all fees and costs, resulting from claims, losses, damages, or cause of actions (including attorneys' fees and expenses of litigation) in connection with the cremation and disposition of the cremated remains of the deceased.

I/We hereby declare that, as the legally authorized person per Florida Statute 497.005(39), of the above-named decedent, I am/we are unable to assume financial responsibility for disposition of the remains. I/We understand that Broward County reserves the right to fully investigate all claims of indigence and, if this form is signed under fraudulent pretenses, Broward County will diligently seek reimbursement of all funds expended by Broward County for the final disposition of the decedent, along with any associated costs.

**Cremains Disposition:** \_\_\_\_ **Legally authorized person will claim ashes (see fee schedule)**

\_\_\_\_ **Scatter as appropriate**

\_\_\_\_\_  
Print Name of Person Authorizing Cremation

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Decedent

\_\_\_\_\_  
Telephone Number (Home, Work, Cell)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Witness (Print Name)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Relationship to Authorized Person

\_\_\_\_\_  
Telephone Number (Home, Work, Cell)