CC301*

Cremation Act 1929

Cremation Amendment Regulations 2008

Made by the Governor in Executive Council.

1. Citation

These regulations are the *Cremation Amendment Regulations 2008*.

2. Commencement

These regulations come into operation on 1 July 2008.

3. The regulations amended

The amendments in these regulations are to the *Cremation Regulations 1954*.

4. Appendix A amended

Appendix A is amended by deleting Forms 6 and 7 and inserting instead —

"

Form 6

Application for Permit to Cremate	*Cremation Act 1929* Form 6
Applicant	Name Address _____
Deceased	Name Address _____
	Date of birth / / Male/Female
	Marital status
	Occupation
**"Nearest surviving relative" is explained at the end of this form.)*	Nearest surviving relative* (if known) Name _____ Relationship _____
	Usual doctor Name _____ Address _____
	Doctor(s) who attended deceased during his or her last illness Name _____ Address _____
Instructions from deceased	Did the deceased leave any written directions about how his or her remains were to be dealt with? ☐ No ☐ Yes. Give details _____
Objections	Do you know of anyone who objects to the deceased's remains being cremated? ☐ No ☐ Yes. Give detail of that person: Name _____ Relationship to deceased _____ Address _____
Coroner	Has the Coroner conducted an investigation or inquest into the deceased's death? ☐ Yes ☐ No ☐ Unsure

Applicant's relationship to deceased *(*"Nearest surviving relative" is explained at the end of this form.)*	☐ Administrator of the deceased ☐ Nearest surviving relative* of the deceased ☐ Other _____ If you are not the Administrator, why are you making the application instead of the Administrator?_____ _____
Details of death	Date / /20 Time a.m./p.m.
	Place where deceased died ☐ Home Address _____ ☐ Hospital _____ Address _____ ☐ Other _____ Address _____
	Do you know, or have reason to suspect, that the deceased's death was directly or indirectly due to any of the following? (*tick if yes*) ☐ violence ☐ poison ☐ privation or neglect ☐ medical procedure ☐ drowning ☐ suffocation ☐ burns Do you have any reason to suppose that an examination of the deceased's remains may be desirable? ☐ No ☐ Yes. Give details _____ _____
Other applications	Have you, or anyone else that you know of, previously applied for a permit to cremate the deceased's remains? ☐ No ☐ Yes. Give details of previous application Made by _____ Date _____/_____/20 _____ Medical Referee to whom it was made _____
Statutory declaration	**I sincerely declare that the information given in this application is true and correct and that I have not omitted any relevant information.** **I know that it is an offence to make a declaration knowing that it is false in a material particular.**
	Signature
	Date / /20
(Witness must be a person authorised to take statutory declarations.)	Witness
	Signature
	Name
	Address _____
Medical referee *(For office use only)*	Permit No.
	Date / /20
	Medical Referee
	Signature
	Name

The **nearest surviving relative** of a deceased person, is the first person who is available from the following persons in the order of priority listed —

(a) a person who, immediately before the death, was living as —
  (i) the spouse of the deceased; or
  (ii) a de facto partner of the deceased and who is at least 18 years of age;
(b) a person who, immediately before the death, was the spouse of the deceased;
(c) a son or daughter of the deceased who is at least 18 years of age;
(d) a parent of the deceased;
(e) a brother or sister of the deceased who is at least 18 years of age.

Form 7

Certificate of Medical Practitioner	*Cremation Act 1929* Form 7
Certificate to be completed by doctor who attended deceased prior to death. Add additional pages if more space is required. Attach copies of all relevant laboratory reports, results, certificates etc.	
Deceased	Name
	Address _____
	Date of birth / / Age
	Marital status
	Male/Female
	Occupation
Doctor	Name
	Address _____
	Are you a spouse, de facto partner or relative of the deceased? ☐ No ☐ Yes Nature of relationship _____
	As far as you are aware, do you have a pecuniary interest in the deceased's estate or any other pecuniary interest in the deceased's death? ☐ No ☐ Yes Give details _____
	Were you the deceased's usual doctor? ☐ No ☐ Yes
Recent care of deceased	During the 4 weeks prior to death did the deceased receive medical or nursing care? ☐ No ☐ Yes Where was the deceased cared for? ☐ Hospital _____ ☐ Nursing home _____ ☐ Home _____ ☐ Other _____ If cared for at home or other place, who provided care? ☐ Professional health care providers ☐ Relatives, friends, others Give names and relationship to the deceased _____ _____

	Did you attend the deceased during his or her last illness? ☐ No ☐ Yes Since what date? / /20
	Did any other doctor(s) attend the deceased during his or her last illness? ☐ No ☐ Yes Give names _____
Last illness	Brief clinical history of last illness including diagnoses and events leading to death. _____ _____ _____
Details of death	Date / /20 Time a.m./p.m.
	Place where the deceased died — ☐ Home Address _____ ☐ Hospital _____ Address _____ ☐ Other _____ Address _____
	Were you present when the deceased died? ☐ Yes ☐ No When did you last see the deceased alive? Date / /20 Time a.m./p.m.
	Did you examine the deceased's body after death? ☐ No ☐ Yes Give details _____
	Do you have any reason to suppose that a further examination of the deceased's remains may be desirable? ☐ No ☐ Yes Give details _____
Cause of death *(* If a Medical Certificate of Cause of Death is attached, answers are not required to these questions.)*	Was a post mortem performed? ☐ No ☐ Yes Give details of results _____ _____
	*Did you sign the Medical Certificate of Cause of Death? ☐ Yes ☐ No Name of the doctor who signed the certificate _____
	*Direct cause of death _____
	*Antecedent causes of death (if any) _____
	*Conditions contributing to or accelerating death (if any) _____

Clinical observations	Do you know, or have reason to suspect, that the deceased's death was directly or indirectly due to any of the following? (*tick if yes*) ☐ violence ☐ poison ☐ privation or neglect ☐ medical procedure ☐ drowning ☐ suffocation ☐ burns
	In view of the deceased's lifestyle and health, do you have any doubts about the character of the deceased's illness or cause of death? ☐ No ☐ Yes Give details _____
Safety of cremation	At the time of death was the deceased fitted with a cardiac pacemaker? ☐ No ☐ Yes Has it been removed ☐ Yes ☐ No
	Had the deceased received any of the following radioactive treatments? • Strontium-89 injection *(e.g. for bone metastases)* during the 12 months prior to death ☐ No ☐ Yes* • Iodine-125 seed implant *(e.g. for prostate cancer)* during the 12 months prior to death ☐ No ☐ Yes* • Samarium-153 during the 2 weeks prior to death ☐ No ☐ Yes* • Rhenium-188 during the 2 weeks prior to death ☐ No ☐ Yes* • Yttrium-90 during the 2 weeks prior to death ☐ No ☐ Yes* * If yes — has the Radiation Safety Officer at the treating institution certified that cremation is safe? ☐ No ☐ Yes Attach certificate
	Are you aware of anything else that could render cremation unsafe? *(e.g. other medical devices, recent treatment etc.)* ☐ No ☐ Yes Give details _____
Certification of medical practitioner	**I certify that the information set out above is true and correct and that I have not omitted any relevant information.**
	Signature
	Date / /20

".

By Command of the Governor,

G. M. PIKE, Clerk of the Executive Council.