



State of Ohio  
**Board of Embalmers and Funeral Directors**

77 South High Street, 16th Floor, Columbus, OH 43215-6108 • Phone (614) 466-4252 • Fax (614) 728-6825  
E-Mail: oh.emb.bd@funeral.ohio.gov • Website: www.funeral.ohio.gov

## EMBALMER REPORT

REPORT # \_\_\_\_\_ DATE \_\_\_\_\_

Apprentice's Name: \_\_\_\_\_ Registration# \_\_\_\_\_  
Currently in month \_\_\_\_\_ of a \_\_\_\_\_ month apprenticeship.

Master's Name: \_\_\_\_\_  
Funeral Home Name: \_\_\_\_\_  
Funeral Home Address: \_\_\_\_\_  
Funeral Home County: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_

### IDENTIFICATION

Name of deceased: \_\_\_\_\_  
Date of Death: \_\_\_\_\_  
Time of Death: \_\_\_\_\_  
Attending physician: \_\_\_\_\_  
Place of removal: \_\_\_\_\_  
Cause of death: \_\_\_\_\_  
Personal effects: \_\_\_\_\_

Identifying marks and deformities:

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Race: \_\_\_\_\_  
Approx. Weight: \_\_\_\_\_ Approx. Height: \_\_\_\_\_  
Teeth: UPPER Natural False None Teeth: LOWER Natural False None

### CONDITION OF BODY PRIOR TO EMBALMING (circle all that apply)

Evidence of Disease	Eruptions	Gas
Emaciation	Skin Slip	Mutilations
Evidence of Surgery	Post-mortem Pigmentation	Purge
Evidence of External Wound	Tumors	Rigor Mortis
	Ulceration	Other

Autopsy: (type) \_\_\_\_\_

Organs or body parts donated: \_\_\_\_\_

Type of Accident: Drowning Suicide Homicide N/A

What was different about this body and how did it affect your embalming process?  
\_\_\_\_\_  
\_\_\_\_\_

EMBALMING Be specific to this case when indicating vessels used and amounts of fluid

Actual Embalmer \_\_\_\_\_

Elapsed time between death and start of embalming \_\_\_\_\_

Arteries used in injection \_\_\_\_\_

Veins used for drainage \_\_\_\_\_

Auxiliary drainage methods used \_\_\_\_\_

Method of injection: Hand Pump Gravity Pressure Machine

Fluids used (trade name \_\_\_\_\_

Pre-injection Arterial Cavity

Arterial Fluids dilution (oz/gallon): \_\_\_\_\_

Cavity fluids (oz injected undiluted): \_\_\_\_\_

Other cavity treatment: \_\_\_\_\_

Parts receiving poor circulation: \_\_\_\_\_

Treatment: \_\_\_\_\_

Restorative art treatment: \_\_\_\_\_

Cosmetics used: \_\_\_\_\_

Length of time required to complete operation: \_\_\_\_\_

Describe what was unique about this embalming. What problems did you encounter? Were there any circulatory problems? If this was a difficult embalming what made it that way?

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

CONDITION OF BODY AFTER EMBALMING

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

Condition of body at time of funeral: \_\_\_\_\_

Special post-embalming treatment required: \_\_\_\_\_

Remarks by apprentice: \_\_\_\_\_

What did you learn from this embalming? \_\_\_\_\_

\_\_\_\_\_

**Indicate Below Your Level of Participation in each Task on this Case:**

**(P) Performed (A) Assisted (O) Observed (N) No Involvement**

Apprentice Participation	Embalming Task	Master Comments
	Verified permission to embalm from authorizing agent	
	Used universal precautions	
	Removed from stretcher or cot to preparation table	
	Positioned on preparation table	
	Performed pre-embalming analysis	
	Bath, shampoo and disinfect	
	Set facial features	
	Discussed and selected of injection and drainage sites	

	Discussed and selected techniques for raising vessels	
	Discussed and selected chemical mixture	
	Discussed and selected injection and drainage methods	
	Operated and maintained embalming machine	
	Performed maintenance	
	Discussed and selected aspiration techniques	
	Discussed and selected cavity treatment	
	Discussed and selected methods of closing incisions	
	Discussed and selected suturing techniques	
	Performed restorative techniques	
	Assisted in preparation of remains for viewing	
	Assisted in dressing	
	Assisted in cosmetizing	
	Assisted in casketing	
	Assisted in scheduling and observing the beautician, barber or cosmetologist	

I attest to the completeness and accuracy of the information contained on this report.

Signed and certified by:

\_\_\_\_\_  
Printed name of Apprentice

\_\_\_\_\_  
Registration #

\_\_\_\_\_  
Signature of Apprentice

\_\_\_\_\_  
Daytime Phone

\*\*\*

I certify that this is an accurate report on the participation of the above-named apprentice in this case.

Signed and certified by:

\_\_\_\_\_  
Printed name of Master

\_\_\_\_\_  
License #

\_\_\_\_\_  
Signature of Master

\_\_\_\_\_  
Daytime Phone

Completion of this form is required by Section 4717.06(6) and Administrative Rule 4717-4-03(B)(6) and 4717-4-04(B)(6).