FERTILITY CENTERS OF ILLINOIS – "FCI" AND GAMETE RESOURCES, INC. – "GRI"
DISPOSITION OF EMBRYOS TO RESEARCH

(For Office Use:
Apply Patient Label Here)

Print Patient's Full Name _____ **Date of Birth** _____

Print Partner's Full Name (if applicable) _____ **Date of Birth** _____

There is a tremendous need for research on human embryos to answer many questions about normal reproduction, infertility and genetics. However, there are very few human embryos available for such purposes. All research involving human subjects and human embryos is carefully monitored by an Institutional Review Board (IRB) composed of members of the medical and general community, with additional ethical and legal expertise. All proposals are carefully considered for their scientific merit and adherence to ethical guidelines. By donating to the bank of human embryos, you make your embryos available for future research projects, including stem cell research.

I/We have embryos that have been cryopreserved and are currently in the custody of "FCI and GRI". I/We have decided against using such embryos to attempt a pregnancy for ourselves and have determined that I/we do not wish to donate such embryos to another couple. However, it has been explained to me/us that there are many varied research projects designed to study problems of infertility (such as implantation rates) or genetic abnormalities, which utilize the study of embryos to help advance scientific knowledge. I/We have decided to donate the cryopreserved embryos designated below for research purposes.

I/We understand:

Patient	Partner	
_____	_____	That the embryos designated below once donated, will not be available for establishing a pregnancy;
please initial		

Patient	Partner	
_____	_____	That there has been no representation made to me/us as to the specific research project that will receive such embryos, although any such research study will be one which has the approval of an Institutional Review Board in conformity with guidelines established by the American Society of Reproductive Medicine;
please initial		

Patient	Partner	
_____	_____	That no representation has been made to me/us that the research study receiving such embryos will have any speciflc result; and
please initial		

Patient	Partner	
_____	_____	I/We understand that we may never benefit personally from any research using these embryos;
please initial		

Patient	Partner	
_____	_____	I/We understand that if the research study succeeds in identifying clinically useful information that might prove of scientific value, such information may be made public;
please initial		

Patient	Partner	
_____	_____	I/We understand that our donation of embryos to research will be treated confidentially and that there will not be any identification of us in any publication or public announcement of the results of any study using my/our donated embryos;
please initial		

Patient	Partner	
_____	_____	That prior to the use of my/our embryos, l/we will be advised of the nature of the study and the fact that it has received the approval of an Institutional Review Board.
please initial		

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FOR LAB USE ONLY
Please do not mark inside box

IDENTIFICATION OF EMBRYO(S) TO BE DONATED TO RESEARCH

Date of Oocyte Retrieval (Month, Date, Year)	Date of Cryopreservation (Printed on Vessel Housing Specimen) (Month, Date, Year)	Identification # (Printed on Vessel Housing Specimen)	Name (Printed on Vessel Housing Specimen)
____, ____, ____	____, ____, ____	_____	_____
____, ____, ____	____, ____, ____	_____	_____
____, ____, ____	____, ____, ____	_____	_____

RELINQUISHMENT OF ALL RIGHTS TO THE EMBRYO(S)

I/We have been advised, and have had the opportunity, to consult our own legal counsel. I/We have also had the opportunity to consult with a physician and psychologist/counselor. I/We have considered all of the information provided to me/us, from various sources, and knowingly relinquish all rights of any kind to the embryo(s).

I/We have considered all the information to me/us and agree to the above mentioned options that I/we have indicated.

Patient Section

_____ _____
Patient Signature — Date

_____
Printed Name of Notary for Patient

_____ _____
Signature of Notary for Patient — Place Notary Stamp for Patient Below — Date

Partner Section (if applicable)

_____ _____
Partner Signature — Date

_____
Printed Name of Notary for Partner

_____ _____
Signature of Notary for Partner — Place Notary Stamp for Partner Below — Date

Consents signed outside the practice must be notarized and dated.

Please keep a copy and mail original to: Cryovault, Inc., P.O. Box 136, Highland Park, IL 60035

For Physician Use Only

The above-mentioned woman/couple has been informed and counseled by me and others regarding the presented as demonstrated by our discussion and the responsive nature of the participation of the woman/couple.

_____ _____
Physician — Date