

FERTILITY CENTERS OF ILLINOIS – “FCI” AND GAMETE RESOURCES, INC. - “GRI”

(For Office Use: Apply Patient Label Here)

TRANSFER/RECEIPT OF CRYOPRESERVED SPECIMEN(S)

We, _____ and _____, as rightful and legal owners,
Patient
Partner (if applicable)
 have made arrangements to have my/our cryopreserved (frozen) specimen(s) transferred to Gamete Resources, Inc. for the purposes of establishing a pregnancy.

The transferring storage facility is:

Please list name and address of facility where frozen specimen(s) is/are coming <i>from</i>	Name of facility _____ Address, City State, Zip _____ Contact Name and Phone # _____
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Please initial only next to the type of specimen being transferred.	Section A & B to be completed by specimen owners		Section C, D, E & F to be completed by GRI upon receipt of specimen(s)			
	Section A	Section B	Section C	Section D	Section E	Section F
	Please Initial patient/partner	Type of Specimen	Date Frozen	Date /Time Received	Specimen ID Number	Condition Tank/Specimen
/	Embryo(s)					
/	Sperm					
/	Epididymal aspirate					
/	Testicular tissue					
/	Oocyte(s) (Egg(s))					

Received by: _____

I/We acknowledge that it is solely my/our responsibility to arrange for the transportation of the frozen specimen(s) via a courier service that is authorized to transport biological materials. The Center may suggest the name(s) of a courier service that may be used; however, I understand that I may contract with another authorized courier service. I/We agree to notify the Center when the arrangements for the transfer of my/our frozen specimen(s) have been made and will provide an estimated arrival date.

I/We acknowledge that the transportation of frozen specimen(s) entails certain risks, including damage to or loss of the shipping tank, which may irreversibly impair, damage or destroy the frozen specimen(s) making the frozen specimen(s) unsuitable for use in establishing a pregnancy.

I/We request to use a cryopreservation shipping tank provided by the Center for the transfer of my/our frozen specimen(s) from the current storage facility location. I/We acknowledge that the frozen specimen(s) must be returned to the Center location on the same day the cryopreservation shipping tank was released to the courier. The Center will use a cryopreservation shipping tank and packing materials in accordance with the policies and procedures established by the Center for the transfer of frozen specimen(s) to the Center.

Post Transfer Disposition

Please initial	_____ patient/partner	I/We acknowledge that the frozen specimen(s) will be placed in cryopreservation storage at the Center and I/we will be responsible for any cryopreservation storage fees. I/We acknowledge that at any time I/we may choose an alternative frozen disposition choice by signing a cryopreservation specimen disposition consent form.
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Specimen Cryopreservation Disposition Options

- A. I/We agree to the following disposition of my/our frozen specimen(s) if I/we decide not to use my/our frozen specimen(s) to establish a pregnancy or after 5 years of cryopreservation storage: **Choose one option only**

Please initial one

_____ Transfer specimen(s) to a long term storage facility at our own expense
patient/partner

OR

_____ Discard according to acceptable laboratory standards
patient/partner

B. Death, Mental Incapacity or Disappearance

Please initial both 1 and 2

1. _____ In the event of death, mental incapacity or disappearance of one of us, I/we request that any and patient/partner all frozen specimen(s) in storage at the Center become the property of the survivor who will have full authority regarding the disposition of the frozen specimen(s), which may include:

- Continued cryopreservation storage at our expense
- Transfer to a long term cryopreservation storage facility
- Donation to research, if permitted by law
- Donation to another person or couple
- Use to establish a pregnancy
- Discard according to acceptable laboratory standards

AND

2. _____ In the event of death, mental incapacity or disappearance of both of us, I/we assign all decisions, patient/partner ownership and/or other rights regarding the disposition of any and all frozen specimens surviving us to the following person and agree to notify him/her of our decision:

Friend or Family Member
to be responsible
or DISCARD

Name

Address, City, State, Zip

Phone # and email address

C. Divorce or permanent separation – **Choose one option only**

In the event of divorce or a permanent separation, I/we request that any and all frozen specimens in storage at the Center:

Please initial only one

_____ Become the sole property of the patient, who shall have the sole authority regarding disposition patient/partner and who may store, dispose, donate to research or another person or couple, or use them in an attempt to establish a pregnancy.

OR

_____ Become the sole property of the partner, who shall have the sole authority regarding disposition patient/partner and who may store, dispose, donate to research or another person or couple or use them in an attempt to establish a pregnancy.

OR

_____ Discard according to acceptable laboratory standards.
patient/partner

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I/We understand that the disposition of specimen(s) produced utilizing donor gametes shall be the decision of both parties if both donor eggs and donor sperm were used. If one of the owners produced the gamete(s), then he or she will have the sole decision making authority over the disposition of the frozen specimen(s).

I/We agree that if any dispute arises between the two of us regarding disposition of the frozen specimen(s), the Center is authorized, at its sole discretion, to refrain from taking any action unless and until otherwise directed by a final judgment or a court of competent jurisdiction or by another agreement signed by both parties. The Center is entitled to rely on a written agreement provided to us and shall have no obligation to inquire into its validity or enforceability.

I/We agree for me/ourselves and my/our successors and heirs to reimburse and indemnify the Center, its affiliates, subsidiary companies, their employees and independent contractors for any loss, expense, cost or damage, reasonable attorney fees that may be incurred by reason of any dispute between the specimen owners regarding the disposition of their frozen specimen(s).

Cryopreservation Storage

I/We hereby agree:

- To timely pay cryopreservation storage fees;
 - Promptly notify the Center in writing of any change in my/our address during the period my/our frozen specimen(s) are being stored;
 - Should I/we fail to pay storage fees or notify the Center of a change of address the Center will attempt to contact me/us by certified mail at my/our last known address. If contact can not be made in this manner or if I/we refuse to pay storage fees, I/we agree that the Center is authorized to discard my/our frozen specimen(s) according to acceptable laboratory standards;
 - Should the Center cease to provide cryopreservation storage, for any reason, I/we will be given 30 days advance notice of cessation of these services via contact at the last known address provided to the Center. If I/we can not be located or I/we fail to make alternative arrangements for my/our frozen specimen(s), I/we agree that the Center is authorized to discard my/our frozen specimen(s) according to acceptable laboratory standards after the 30 days notice time frame has expired;
 - The Center may, under certain circumstance, transfer my/our frozen specimen(s) to another location without additional authorization from me/us;
 - In the event the frozen specimen(s) have been in storage for 5 years after final treatment, or by the patient’s 51st birthday, the Center will contact me/us at my/our the last known address to elicit my/our final frozen specimen disposition choice, which may include:
 - Transfer to a long term cryopreservation storage facility
 - Donate to research, if permitted by law
 - Donate to another person or couple
 - Discard according to acceptable laboratory standards
- If the Center can not locate me/us or if I/we do not elect a final frozen specimen disposition choice, I/we agree that the Center is authorized to dispose of my/our frozen specimen(s) according to acceptable laboratory standards; and,
- Once frozen specimen(s) are removed from the Center they may not be transferred back for any reason, including assisted reproduction treatment.

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Limitations of Cryopreservation Services

I/We acknowledge that:

- There is no known effects from the long term storage of cryopreserved specimen(s);
- Loss or damage to the frozen specimen(s) may result from power failure, loss of liquid nitrogen, mechanical failure or accident, governmental interferences or regulations, acts of war or acts of God;
- There is no guarantee that the specimen(s) will survive the freezing and thawing process which will make them unusable to establish a pregnancy; and,
- Data from the U.S. and abroad suggests that the rate of birth defects in children born following cryopreservation of specimen(s) is the same as the rate observed in an age-matched group of pregnant women who conceived without assisted reproduction .

Attestation

I/We agree to hold harmless, indemnify and release the Center, their agents, employees, representatives and physicians from any and all responsibility for the safety and integrity of the frozen specimen(s) as a result of any defect in the cryopreservation shipping tank and/or for the handling, transportation and storage of the cryopreservation shipping tank by the courier and/or once the cryopreservation shipping tank is no longer in possession and control of the Center.

I/We have carefully read this agreement, have had the opportunity to ask questions and have all my/our questions answered to my/our satisfaction and fully understand its contents. I/We are aware that this form releases the Center, its agents, employees, representatives and physicians from any and all responsibility for the safety and integrity of the frozen specimen(s) during the transfer and transportation of my/our specimen(s) to the Center. I/We acknowledge that I/we have signed this consent of my/our own free will.

Patient Signature

Date

Partner Signature (if applicable)

Date

Photo Identification:

Patient Type: _____

Exp. Date: _____

Partner Type: _____

Exp. Date: _____

Witness Name

Signature and Title

Date Reviewed

Signatures of consenting parties must be notarized if the consent is signed outside the presence of a Center employee.

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**Notary/Witness
Attestation**

Patient

State of _____ County of _____

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated _____ Notary/Witness Signature _____

My appointment expires: _____

Partner (if applicable)

State of _____ County of _____

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be him/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated _____ Notary/Witness Signature _____

My appointment expires: _____