



Reproductive Technologies, Inc.
THE SPERM BANK OF CALIFORNIA

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**MEDICAL PROFESSIONAL ANNUAL SIGNATURE FORM
 REQUIRED FOR THE PURCHASE OF SEMEN**

(This form is required at the time of Registration and needs to be Updated with a signature every 12 months)

Today's Date: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> _____ month _____ day _____ year </div>

I _____ **certify that I am the Medical Professional for below named Recipient.**
 (Doctor's Printed Name)

1. I understand that my patient is purchasing sperm samples from THE SPERM BANK OF CALIFORNIA to be used for artificial insemination or other methods of assisted reproduction.
2. I agree that I and/or my patient will take responsibility for the receipt, storage, and care of any sperm samples I receive from THE SPERM BANK OF CALIFORNIA (TSBC).
3. I understand that THE SPERM BANK OF CALIFORNIA is not responsible for any damage to the samples that may occur during the transport or shipping process, or due to subsequent storage at another facility.
4. I understand that samples transported in dry ice should be used or stored within twenty-four hours of receipt and that samples transported in liquid nitrogen vapor tanks should be used or stored within seven days of receipt.
5. I understand that I will be asked to sign a new Signature Form for my patient every 12 months, for as long as she is a recipient with TSBC.

Medical Professional's Signature: _____

TSBC Recipient/Patient Name: _____

Medical Professional's Name: _____

Medical Group or Clinic Name: _____

Street Address: _____

City, State, Zip _____

In Office Use: Recipient Account # _____	Date: ____ / ____ / ____	Staff: _____
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