Reproductive Technologies, Inc.

THE SPERM BANK OF CALIFORNIA

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MEDICAL FACILITY REGISTRATION

This form is required at the time of Registration if your Clinic is not already in our system.

Physician Name _____ **Patient Name** _____

Name of Practice and/or Associate(s) _____ Type of practice _____

_____

Street Address City State Zip

Telephone ____-_____-_____ Fax _____-_____-_____ License # _____

REQUIRED ☐ A photocopy of my Practicing License OR a Voided Prescription is attached.

I understand that The Sperm Bank of California (TSBC) is registered as a reproductive tissue bank with the FDA (U.S. Food and Drug Administration) and is in full compliance with FDA regulations governing donor screening and testing.

I understand that all TSBC donors are recruited from the general population, and that prior to acceptance each applicant goes through a two month screening process, during which TSBC evaluates his fertility, takes a health history, provides a thorough medical examination, assesses his risk status for sexually transmitted diseases and tests his blood, semen and urine for infectious diseases. Genetic testing includes screening for cystic fibrosis carrier status, for hemoglobin electrophoresis (for sickle cell anemia and thalassemia carrier status), screening for Spinal Muscular Atrophy (starting in 2013) and, when indicated, for Tay Sachs carrier status and a panel for donors of Jewish ancestry.

I understand that TSBC screens all donors for the following sexually transmitted diseases: gonorrhea, chlamydia, syphilis and antibodies to hepatitis B, hepatitis C, cytomegalovirus (CMV), Human T cell Lymphotropic Virus Types 1 and 2 (HTLV-1 and HTLV-2), HIV-1 and HIV-2. All sperm samples are quarantined for a minimum of 180 days and donors are repeatedly tested for the above-mentioned diseases as long as they are collecting samples and after quarantine.

I understand that although TSBC guarantees that the appropriate tests have been performed by its reference laboratory, laboratory tests are not 100% accurate and TSBC cannot guarantee the absence of sexually transmitted diseases, inheritable illnesses or inheritable birth defects resulting from insemination with donor sperm.

I understand that thawed frozen sperm will not survive as long as fresh sperm and that insemination should take place as close to the time of ovulation as possible. I understand that TSBC cannot guarantee that pregnancy will occur as a result of donor insemination, and I agree to inform my patient of the limitations and risks of artificial insemination.

I understand that TSBC guarantees a post-thaw minimum of 20 million motile sperm per cc and 20% motility in every washed (IUI) sample and a post-thaw minimum of 20 million motile sperm per cc and 15% motility in every unwashed (ICI) sample. As samples that have been washed for IUI are .5cc in volume, this guarantee translates to 10 million motile sperm per IUI-ready vial.

I understand that the state of New York prohibits TSBC from shipping sperm samples from donors who have sex with other men to recipients in New York. These donors are identified in TSBC's catalog with the notation "no NY."

I agree that I and/or my patient will take responsibility for the receipt, storage, and care of any sperm samples I receive from TSBC. I understand that TSBC 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. I understand that samples transported in dry ice should be used within twenty-four hours of receipt and that samples transported in liquid nitrogen vapor tanks should be used within seven days of receipt. Samples that will not be used within the timeframes indicated should be stored in liquid nitrogen tanks or returned to TSBC before the timeframe ends.

My patient is purchasing sperm samples from TSBC. These samples are to be used by this patient only and will not be used by other patients without first registering with TSBC.

I agree to sign my patient's **MEDICAL PROFESSIONAL ANNUAL SIGNATURE FORM** and to notify TSBC promptly of all resulting pregnancies and any suspected or known adverse reactions.

Physician's Signature _____ **Date** _____