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 FOR REGISTRATION AND NEEDS TO BE UPDATED EVERY 12 MONTHS)

Today's Date: _____ _____ _____
month day year

I _____ certify that I am the Medical Professional for
(Doctor's Printed Name)

Recipient _____.
(Recipient 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. If sperm samples are shipped to my facility, I understand that I will take responsibility for the receipt, storage, and care of those samples received from THE SPERM BANK OF CALIFORNIA (TSBC).

3. I understand that THE SPERM BANK OF CALIFORNIA is not responsible for any damage to samples that may occur 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 they are a recipient with TSBC.

Medical Professional's Signature:_____

Medical Professional's Name: _____

Medical Group or Clinic Name:_____

Street Address:_____

City, State, Zip_____Phone:_____

ALL FIELDS REQUIRED