Reproductive Technologies, Inc.

THE SPERM BANK OF CALIFORNIA

2115 Milvia Street, Berkeley, Ca 94704 Tel. 510.841.1858 Fax 510.841.0332 Email: staff@tsbca.org

FORMULARIO DE FIRMA ANUAL PARA DOCTORES
REQUERIDO PARA LA COMPRA DE SEMEN

(ESTE FORMULARIO ES OBLIGATORIO PARA EL REGISTRO Y NECESITA SER ACTUALIZADO CADA 12 MESES)

Fecha actual: ____________________
mes/dia/año

Yo ______________________________ certifico que soy el Medico Profesional del
(Nombre del Doctor en Impreso)

Receptora ____
(Nombre del Receptora)

1. Reconozco que mi paciente comprara muestras de semen de THE SPERM BANK OF CALIFORNIA (TSBC) para ser usadas en inseminación artificial u otro método de reproducción asistida.
2. Si las muestras de semen son enviadas a mis instalaciones, comprendo que tengo la responsabilidad de recibir, almacenar, y cuidar las muestras enviadas por THE SPERM BANK OF CALIFORNIA.
3. Si las muestras de semen son enviadas directamente a mi paciente, comprendo que mi paciente tendrá la responsabilidad de recibir, almacenar, y cuidar las muestras enviadas por THE SPERM BANK OF CALIFORNIA
4. Comprendo que THE SPERM BANK OF CALIFORNIA no se responsabiliza por ningún daño que le ocurran a las muestras debido al almacenaje en otra instalación o el hogar de mi paciente.
5. Comprendo que las muestras transportadas en tanques de vapor de liquido de nitrógeno deben ser usadas o guardadas dentro de siete días.
6. Comprendo que mi paciente me pedirá firmar un Formulario de Firma cada 12 meses, mientras sea un(a) receptor(a) de TSBC.

Firma del Profesional Medico:______________________________

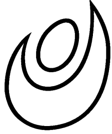
Nombre del Profesional Medico:____

Nombre del Grupo Medico o Clínica:____

Dirección:____

Ciudad, Estado, Zip:_______________________________ Tel.____________________

TODOS LOS CAMPOS SON OBLIGATORIOS



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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 (TSBC) 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 samples received from THE SPERM BANK OF CALIFORNIA.

3. If sperm samples are shipped to my patient directly, I understand that my patient will take responsibility for the receipt, storage, and care of samples received from THE SPERM BANK OF CALIFORNIA

4. 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 or my patient's home.

5. I understand that samples transported in liquid nitrogen vapor tanks should be used or stored within seven days of receipt.

6. 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