Reproductive Technologies, Inc.
THE SPERM BANK OF CALIFORNIA
2115 Milvia Street, Berkeley, Ca 94704 Phone 510.841.1858 Fax 510.841.0332 Email: staff@tsbca.org

MEDICAL PROFESSIONAL SIGNATURE FORM

(THIS FORM IS REQUIRED FOR RECIPIENT OF PERSONAL STORAGE CLIENT REGISTRATION)

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 using sperm samples from personal storage Client/Donor _____ 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.

Medical Professional's Signature: _____

Medical Professional's Name: _____

Medical Group or Clinic Name:_____

Street Address:_____

City, State, Zip_____Phone:_____

ALL FIELDS REQUIRED