



Cryopreservation Intended Use form

FCC ACCT # _____

Client Depositor Name: _____ Date of Birth: ___/___/___

Spouse / Partner Name: _____ Date of Birth: ___/___/___

Valid Form of Government Identification for Spouse/Sexually Intimate Partner must accompany this form if frozen specimen is to be used by any person other than the client depositor.

<input type="checkbox"/> Pre-vasectomy	<input type="checkbox"/> Occupational Hazard	<input type="checkbox"/> Pre-surgery
<input type="checkbox"/> Pre-Chemo/Radiation Therapy	<input type="checkbox"/> Other:	

Intended Use of Frozen Specimen:

<input type="checkbox"/> ICI*	<input type="checkbox"/> IUI**	<input type="checkbox"/> IVF***
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*ICI requires, on average, 10 normal count sperm samples to achieve 1 pregnancy

**IUI requires, on average, 6 normal count sperm samples to achieve 1 pregnancy

***IVF requires, on average, 2 normal count sperm samples to achieve 1 pregnancy

Do you have other reproductive tissue stored at any other locations? (Circle one) YES NO

If Yes, where? _____

How many children do you wish to have in the future from sperm which is to be frozen at the Fertility Center of California? _____

Your signature below acknowledges that the reproductive materials and or specimens provided to FCC/FFC for the purposes of long term storage have been produced and are the property of the undersigned. It is understood and agreed that future serology testing may be required for storage and or release of these specimens.

Signature _____ date ___/___/___

If the patient above is a minor, a parent or guardian of the minor must sign below:

_____ signature parent or guardian if applicable

I _____ authorize _____ to use my frozen sperm samples for reproductive purposes.
Client Depositor Spouse/Sexually Intimate Partner(SIP)

I also agree to contact FCC/FFC if above spouse/SIP is no longer authorized to utilize my frozen vials for reproductive purposes.

 Signature of Client Depositor

_____/_____/_____
 Date