Statement of Understanding for Directed Donor

CryoGam Colorado, LLC 2216 Hoffman Dr., Unit B Loveland, CO 80538 800-473-9601

Name (Directed Donor): _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ Alternate Phone:_____ Email:_____

Are you the Intended Parent? □ YES (complete page 1) □ NO (complete page 2) □ Unsure (complete pages 1 and 2)

Please read the following statements of understanding regarding the directed donor program.

1. I understand that all fees are non-refundable and are due at the time of service regardless of the specimen quality, test results, donor eligibility or specimen use. I understand that if I do not complete the screening, testing, and release process according to CryoGam's requirements, no fees will be reimbursed and specimens will not be eligible for release.
2. I understand that CryoGam's satellite offices have limited appointment times. I understand that I may have to travel to the Loveland office in order to complete parts of the directed donor program. I understand that if I do not call and cancel my appointment within 24 hours of my scheduled appointment, I may be charged a $50.00 cancellation fee.
3. I understand that I must provide written authorization for the Recipient(s) to use my cryopreserved sperm for artificial reproductive procedures. I also understand that I must authorize CryoGam to release and discuss medical information with any Recipient(s) and/or their physician. I understand that if I wish to revoke the release of my specimens or medical information I must do so in writing.
4. I understand that CryoGam is not liable for communication and/or agreements between the directed donor and Recipient(s).
5. I understand that CryoGam will determine donor eligibility for directed donors. I understand that certain medical history, behaviors, risk factors and test results may deem me an ineligible directed donor at any time throughout the process.
6. I understand that under certain circumstances I *may* be allowed to proceed as an ineligible directed donor. I understand that my Recipient(s)' physician is required to approve the use of an ineligible directed donor prior to CryoGam releasing the sperm specimens for use in an artificial reproductive procedure. I also understand that certain reasons for ineligibility may not be waived and such reasons are at the sole discretion of CryoGam.
7. I understand that CryoGam requires all specimens to remain in quarantine for a period of 180 days. At the end of the 180 day quarantine period, I understand that I must complete a physical and retesting in order for CryoGam to finish the donor eligibility process. I understand that under no circumstances will the specimens be released, shipped, or used prior to the 180-day quarantine and retesting requirements.
8. I understand that it is my responsibility to contact CryoGam with inquiries regarding test results and to schedule follow up appointments, including the retesting and physical exam after the 180-day quarantine.
9. I understand that screening and testing does not guarantee sperm quality nor does it guarantee that I will be deemed an eligible donor or that cryopreserved sperm specimens will be released for use.
10. I understand that my physician may require additional testing for directed donors. I understand that it is my responsibility to request that CryoGam perform any additional tests or requirements. I understand that there are additional fees for these services and that not all requests can be completed.
11. I understand that I must notify CryoGam, in writing, if I decide not to proceed with the directed donor program.

I have read and understand all the statements of this Agreement and do hereby wish to proceed as a directed donor.

_____ _____

*Signature Date

**Note: If this form is not signed in the presence of a CryoGam employee, please include a copy of your valid photo ID.*

_____ _____ OR _____ _____

CryoGam Witness Date Received By Date

If you are NOT the Intended Parent, please complete the following information regarding the Intended Parent(s)/Recipient(s):

Primary Intended Parent/Recipient Name: _____ DOB: _____

Additional Intended Parent/Recipient Name: _____ DOB: _____

Please read the following statements of understanding regarding the directed donor program.

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2. I understand that any financial contribution by Intended Parent(s)/Recipient(s) does not entitle nor ensure the Intended Parent(s)/Recipient(s) access to my health information or cryopreserved sperm specimens. I understand that regardless of which party pays for the services, I may withdraw my permission for use of the cryopreserved sperm at any time.
3. I understand that CryoGam's satellite offices have limited appointment times. I understand that I may have to travel to the Loveland office in order to complete parts of the directed donor program. I understand that if I do not call and cancel my appointment within 24 hours of my scheduled appointment, I may be charged a $50.00 cancellation fee.
4. I understand that I must provide written authorization for CryoGam to release and discuss medical information with Intended Parent(s)/Recipient(s) and/or physician. I understand that I if I wish to revoke the release of information I must do so in writing.
5. I understand that I must provide written authorization for the Intended Parent(s)/Recipient(s) to use my cryopreserved sperm for artificial reproductive procedures. I also understand that I have the option to retain full control over the storage and destruction of my sperm samples or I can request that the Primary Intended Parent/Recipient be responsible for the payment of all future storage invoices. I understand that the Primary Intended Parent/Recipient must sign a storage agreement with CryoGam in order to assume control of the storage and destruction of specimens. I understand that the release of specimens to the Additional Intended Parent/Recipient must be authorized by both the directed donor and the Primary Intended Parent/Recipient.
6. I understand that CryoGam is not liable for communication and/or agreements between the directed donor and the Intended Parent(s)/Recipient(s).
7. I understand that CryoGam will determine donor eligibility for directed donors. I understand that certain medical history, behaviors, risk factors and test results may deem me an ineligible directed donor at any time throughout the process.
8. I understand that under certain circumstances I *may* be allowed to proceed as an ineligible directed donor. I understand that the Intended Parent(s)/Recipient(s)' physician is required to approve the use of an ineligible directed donor prior to CryoGam releasing the sperm specimens for use in an artificial reproductive procedure. I also understand that certain reasons for ineligibility may not be waived and such reasons are at the sole discretion of CryoGam.
9. I understand that CryoGam requires all specimens to remain in quarantine for a period of 180 days. At the end of the 180 day quarantine period, I understand that I must complete a physical and retesting in order for CryoGam to finish the donor eligibility process. I understand that under no circumstances will the specimens be released, shipped, or used prior to the 180-day quarantine and retesting requirements.
10. I understand that it is the responsibility of the directed donor and/or the Intended Parent(s)/Recipient(s) to contact CryoGam with inquiries regarding test results and to schedule follow up appointments, including the retesting and physical exam after the 180-day quarantine.
11. I understand that screening and testing does not guarantee sperm quality nor does it guarantee that I will be deemed an eligible donor or that cryopreserved sperm specimens will be released for use.
12. I understand that Intended Parent(s)/Recipient(s)' physician may require additional testing for directed donors. I understand that it is the responsibility of the directed donor and/or Intended Parent(s)/Recipient(s) to request that CryoGam perform any additional tests or requirements. I understand that there are additional fees for these services and that not all requests can be completed.
13. I understand that I must notify CryoGam, in writing, if I decide not to proceed with the directed donor program.

I have read and understand all the statements of this Agreement and do hereby wish to proceed as a directed donor.

_____ _____

*Signature Date

**Note: If this form is not signed in the presence of a CryoGam employee, please include a copy of your valid photo ID.*

_____ _____ OR _____ _____

CryoGam Witness Date Received By Date