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### International Identity (ID) Option Birth Registration Form

Shaded boxes ( ) must be filled in.

Congratulations! We have recently received a report of your pregnancy from the use of donor sperm from Fairfax Cryobank or Cryogenic Laboratories, Inc. (hereafter known as Cryobank), that had been obtained from ( ) (Company Name). Since this pregnancy resulted from an Identity (ID) Options donor, as per the agreement originally signed at the time of your order, you **MUST** register the birth of your child with Cryobank in order for him/her at age 18 or older to receive Identifying Information about the donor. **Merely using semen from the Identity (ID) Option donor does not allow access to the Identifying Information. To ensure that the Donor's Identifying Information will be provided, you MUST complete the following information and return this registration form to Cryobank upon the birth of your child or up until they reach the age of 18. If you choose not to register your child, the donor will remain anonymous and your child will not be able to access identifying information once s/he reaches 18 or older.** The information provided below is confidential and will only be used when/if your child requests Identifying Information regarding the donor.

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#### Parent information:

( )

Signature of Recipient

( )

City, Province, Country, Postal Code

( )

Printed Name (First / Surname)

( )

Daytime Phone Number

( )

Address

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#### Physician who performed or oversaw the insemination or embryo transfer procedure:

( )

Printed Name

( )

Clinic name

( )

Address

( )

City, Province, Country, Postal Code

( )

Phone Number

Date of insemination or fresh embryo transfer that resulted in this pregnancy \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
mm / dd / yyyy

Were embryos created and frozen for a future attempt at pregnancy? Yes No

Was this pregnancy a result of transfer of previously frozen embryos? Yes No

If Yes, when were they created? \_\_\_\_\_/\_\_\_\_\_  
mm / yyyy

Cryobank Donor # \_\_\_\_\_ Brand:  FAIRFAX  CLI

**Offspring Information:**

**Offspring 1**

\_\_\_\_\_

Name (First / Surname)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of Birth mm / dd / yyyy

Sex: [ ] Male [ ] Female

\_\_\_\_\_

Social Insurance Number or  copy of birth certificate

**Offspring 2 (if applicable)**

\_\_\_\_\_

Name (First / Surname)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of Birth mm / dd / yyyy

Sex: [ ] Male [ ] Female

\_\_\_\_\_

Social Insurance Number or  copy of birth certificate

**Return form to:** Fairfax Cryobank or Cryogenic Laboratories, Inc  
Attn: Identity (ID) Option Program  
3015 Williams Drive, Ste 110  
Fairfax, VA 22031 USA

*Office use only:*

*Date form received* \_\_\_\_\_

*Order/donor verified* \_\_\_\_\_

*Physician confirmed* \_\_\_\_\_