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| DATE EFFECTIVE: 06/14/10 | Agreement for Use of Frozen Donor Semen Specimens | FORM: DIS.10t REV: C.01 |
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We, the undersigned recipient (and her husband or other partner, if applicable) ("Recipient"), and her provider of assisted reproductive technology ("ART") services/attending physician ("Facility"), having requested Cryogenic Laboratories, Inc. ("CLI") to provide to Facility cryopreserved human donor semen ("Specimens") to facilitate a pregnancy in Recipient through the use of ART, understand and agree to the following terms and conditions:

Use of Specimens/Parentage: We agree that all Specimens obtained from CLI are for Recipient's personal use only. We understand that we will be fully responsible for all offspring conceived by use of the Specimens.

Identity of Donor: We understand that the identity of the Specimen donor shall remain anonymous. We shall have no right to learn the identity of the donor and agree not to solicit donor identifying information from any other source.

Informed Agreement/Donor Testing: We have received CLI's current Patient Information Packet and understand the nature of testing that has been performed in compliance with the AATB, ASRM and CLIA guidelines and are as accurate as possible with current methodologies. We further understand that while the majority of children are born healthy, there is a risk for birth defect or genetic disease to occur in any pregnancy, whether conceived naturally or through donor insemination. From decades of use and thousands of resulting pregnancies, the use of cryopreserved donor semen has not been associated with risk over and above the background risk inherent in human reproduction.

By executing this Informed Agreement, we acknowledge that the risks and implications of using the Specimens to achieve a pregnancy in Recipient have been fully explained to Recipient's satisfaction and that Recipient has had ample opportunity to ask questions and consult with experts of Recipient's choice.

Authorization for Release of Medical Information to CLI: We authorize the Facility to disclose to CLI information of all pregnancies and birth outcomes resulting from the Specimens in order to determine donor fecundity.

Absence of Warranties/Limit of Liability/Indemnification: We understand that no guarantee can be given that Specimens are disease-free or will result in a pregnancy. We understand that CLI cannot be responsible for the physical or mental characteristics of any offspring conceived as a result of the use of the Specimens. We release CLI, CLI's personnel and the donor from any and all liability and responsibility of any nature whatsoever for complications of pregnancy, childbirth or delivery; the birth of any abnormal child; the genetic, hereditary or hereditary tendencies of such offspring; or any other adverse consequence that may arise in connection with the Recipient's use of the Specimens. We agree that CLI shall not be liable for incidental or consequential damages of any kind to Recipient, Facility, or to any child born as a result of ART procedures utilizing the Specimens. We hereby indemnify CLI, CLI's personnel, and the donor from and against all loss, liability, damage and expense (including reasonable attorneys' fees) of any kind or nature which CLI, CLI's personnel, and donor may suffer or incur by reason of any claim by any party (including any child born as a result of a pregnancy facilitated by the use of the Specimens), which arises from or relates in any way to the Specimens. In any event, the total liability of CLI for failure to meet any of its responsibilities under this Agreement shall not exceed the cost of semen specimens and shipping fees theretofore charged to and paid by the Recipient. The parties agree that any claims relating to or arising out of this Agreement will be brought in the state courts of Minnesota.

Opportunity to consult legal counsel: We have read this Informed Agreement and the Patient Information Packet and we understand and agree to the policies and procedures explained therein. We have had the opportunity to review these documents with our own legal counsel. We execute this Informed Agreement knowingly and freely.

Signature of Recipient/Recipient Identification/ Date
Medical Record Number

Signature of Recipient Partner (if applicable) Date

Signature of Cryogenic Laboratories Inc. Staff/ Date

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Part 1 of 2

**INFORMED AGREEMENT
FOR USE OF FROZEN DONOR SEMEN SPECIMENS**

Recipient

Recipient's Partner

Signature of Recipient/ Recipient Identification/
Medical Record Number

Signature of Recipient Partner (if applicable)

Date

Date

(Please Print Clearly)

(Please Print Clearly)

Name(last) (First) (M)

Name(last) (First) (M)

Address

Address

City State Zip

City State Zip

Social Security Number

Social Security Number

Age Visa/Mastercard Number Exp. Date

Age Visa/Mastercard Number Exp. Date

Home phone Email

Home phone Email

Business phone FAX

Business phone FAX

Name of Responsible Physician

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| <p>Medical Staff Certification</p> <p>I certify that I am a member of the Facility's medical staff assisting Recipient to achieve a pregnancy through the use of assisted reproductive technology and that I or one of my colleagues have discussed, explained, and reviewed with Recipient all aspects of the foregoing Informed Agreement. In my opinion, Recipient fully understands what I said, as well as the matters set forth in the Informed Agreement which has been executed prior to this certification. The assisted reproductive technology procedures will be performed under the direction and supervision of the physician noted below.</p> <p>If the Recipient chooses to remain anonymous, a Recipient Identification/ Medical Record Number has been placed in the space provided above for the signature of the Recipient in lieu of the Recipient signature and name. If a medical record number is placed in the space provided above for the signature of the Recipient, I certify that a copy of this Informed Agreement, signed by the Recipient, and her partner (if applicable), is located in Recipient's medical record at the Facility where I provide reproductive health services to Recipient.</p> | <p>(Please Print Clearly)</p> <p>_____ Name of Recipient</p> <p>_____ Name of Responsible Physician</p> <p>_____ Clinic/Hospital/Center Name</p> <p>_____ Address</p> <p>_____ City State Zip</p> <p>_____ Telephone FAX</p> <p>Specimens should be delivered to the following address if different from above:</p> <p>_____ Address</p> <p>_____ City State Zip</p> <p>_____ Authorized Signature of Medical Staff Member</p> <p>_____ Date</p> <p>Please check billing preference:</p> <p>_____ Bill Physician _____ Bill Recipient</p> |
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Part 2 of 2

CRYOGENICS LABORATORIES, INC.
3015 Williams Drive, Suite 110 Fairfax, Virginia 22031
Voice (651) 489-8000 Fax (651) 489-8989 Toll Free (800) 466-2796
info@cryolab.com