



BIO GENETICS CORPORATION

FDA Registered <> Licensed by New York State Department of Health<> Licensed by New Jersey Department of Health (CLIA)
187 Mill Lane <> Mountainside, New Jersey 07092 <> 908-654-8836 <> 800-637-7776 <> Fax 908-232-2114

PHYSICIAN AUTHORIZATION FORM FOR DIRECT RECIPIENT PURCHASE OF CRYOPRESERVED DONOR SPERM

This document is valid for a period of twelve (12) months from this effective date: _____

I am referring (enter **Recipient's Name**) _____ to BioGenetics Corp.

to obtain cryopreserved donor sperm for an assisted reproduction procedure.

I have informed the above named recipient of the risks, limitations and outcomes of current assisted reproduction procedures associated with the use of cryopreserved donor sperm.

The recipient was advised and has accepted to order the necessary number of cryopreserved donor specimen vial(s) as well as to be responsible for payment to BioGenetics prior to every delivery/shipment.

All specimen(s) obtained from BioGenetics are for the exclusive use of the recipient named in this referral.

All assisted reproduction procedures will be performed under my direction and supervision.

I authorize the above named recipient to obtain cryopreserved donor sperm directly from BioGenetics.

Physician's Signature: _____ Date Signed: _____

Print Name of Physician: _____

Address: _____

Telephone Number: _____ Fax Number: _____

REMINDER

The following documents must be received at BioGenetics Corp. prior to the initial order placement or purchase of cryopreserved donor sperm

PHYSICIAN/MEDICAL FACILITY AGREEMENT FOR THE PURCHASE OF CRYOPRESERVED DONOR SPERM
RECIPIENT ACKNOWLEDGEMENT AND CONSENT FOR THERAPEUTIC ASSISTED REPRODUCTION BY CRYOPRESERVED DONOR SPERM