

University Women's Healthcare-Fertility Center
401 E. Chestnut, Ste. 410 - Louisville, KY 40202
Tel. 502-271-5846; Fax 502-271-5984

FROZEN SPERM DISPOSITION FORM

I, (Client Depositor) _____ D.O.B. _____

request and consent to the disposal of all my frozen:

- sperm (semen or testicular sample(s))
 donor sperm

following the policies and procedures established by the Fertility Center.

Signature (Client Depositor) _____ Date _____

Signature (Client Depositor) _____ Date _____

Guardian (if Client Depositor is a minor) _____ Date _____

Signature (Fertility Center Witness or Notary Public) _____ Date _____

Return this form to: Embryology Laboratory
Fertility Center
401 East Chestnut Street
Suite 410
Louisville, KY 40202

My Current Contact Info is:

Telephone _____
Address _____

Attention: Signatures must be witnessed by Fertility Center Staff or a Notary for the form to be valid

To be completed by Embryology Laboratory

Date(s) frozen _____ # Straws _____ #vials _____

Patient/sample ID Confirmation:

Straw(s)/vial(s) labeled as: _____ Tech _____

Date of sperm thawing and disposal _____ Tech _____