KLINICKÉ CENTRUM ISCARE
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Complementary informed consent to cryopreserved oocytes treatment - request for an extension of the storage period

Name and surname: .....

Date of birth/national identity number (if assigned): .....

Patient identification number (if assigned): .....

štítek/label

ID document number: .....

Patient has stored cryopreserved oocytes at the medical facility. As the time period agreed for their storage has expired by ....., the patient requests at the medical facility prolonging of storage of the cryopreserved oocytes for another ..... year period (starting with the above mentioned date). The patient pledges to pay ISCARE medical facility the cryopreserved **oocytes storage fee** according to the current pricelist the patient has been thoroughly acquainted with.

The purpose of the cryopreserved oocytes storage is their use for IVF treatment of the patient.

In case the patient doesn't request further prolonging of the cryopreserved oocytes storage before the storage period is over, the patient asks ISCARE medical facility to dispose of the oocytes after the time period expiration.

This document is valid only if patient is identified with an identification document before signing this document in ISCARE a.s. or with the signature approved by a legal authority.

In _____ date:

Patient´s signature:

Patient identification when signing in healthcare facilities on behalf of ISCARE Inc. was carried out by (name, surname and signature of the reponsible staff):