KLINICKÉ CENTRUM ISCARE
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Complementary informed consent to cryopreserved sperm 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 sperm at the medical facility. As the time period agreed for its storage has expired by ....., the patient requests at the medical facility prolonging of storage of the cryopreserved sperm for another ..... year period (starting with the above mentioned date). The patient pledges to pay ISCARE medical facility the cryopreserved **sperm storage fee** according to the current pricelist the patient has been thoroughly acquainted with.

The purpose of the cryopreserved sperm storage is its usage for IVF treatment of the patient's wife/partner.

In case the patient doesn't request further prolonging of the cryopreserved sperm storage before the storage period is over, the patient asks ISCARE medical facility to dispose of the sperm 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 responsible staff):