KLINICKÉ CENTRUM ISCARE
ISCARE a.s., Českomoravská 2510/19, 190 00 Praha 9 - Libeň, IČO 61858366
T: +420 234 770 100 / E: iscare@iscare.cz / www.iscare.cz

Declaration of permission to cryopreserved oocytes treatment (disposal)

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 (eggs) at the medical facility.

Patient's statement of consent:

I, the undersigned, hereby request ISCARE a. s., with the registered office at Českomoravská 2510/19, Prague 9, 190 00, Company Number: 61858366, to ensure the disposal of my oocytes, which I have cryopreserved at the medical facility.

The patient hereby gives to the medical device the consent to the disposal of cryopreserved oocytes.

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):