

POWER OF ATTORNEY



Name:

Address:

Zip Code: City:

State: Country:

We, _____ (name and surname),

date of birth _____

and _____ (name and surname),

date of birth _____

give you permission (power of attorney)

to _____ (name and surname of Ark.cryo ivf courier),

date of birth _____

and passport number _____

to transport our

(indicate type of human biomaterial: oocytes, sperm, embryos)

from the _____

_____ (full address of the clinic where the material is stored) to the

_____ (full address of the clinic where cells should be delivered).

Date: Signature:

Date: Signature: