ARK cryo

Clinic _____
Doctor _____
Address _____
Phone _____
E-mail _____

THE TRANSFER ACT

OF CRYOPRESERVED EMBRYOS/ OOCYTES / SPERM/
OVARIAN TISSUE / TESTIS OR ITS EPIDIDYMIS

Information about patient (s)

Wife _____
(Surname, First Name. Patronymic, y.b.)

Passport series _____ number _____, issued _____

Husband _____
(Surname, First Name. Patronymic, y.b.)

Passport series _____ number _____, issued _____

Date of obtaining biological material «____» _____ 20___.

Date of cryopreservation «____» _____ 20___.

Method of cryopreservation (free freezing method, method of vitrification) _____

Name and manufacturer of cryopreservation kit _____

Type of carrier used (straws, vials) with Manufacturer details

DISTRIBUTION BY CARRIERS:

No. of carrier	Marking	Content of carrier (sperm, oocytes, embryos, testis fragment tissue, ovarian fragment tissue, suspension)	Quantitative characteristics (number of spermatozoa in 1 ml, number of embryos, tissue or suspension volume)	Comments (qualitative characteristics, stage of embryogenesis, qualitative characteristics of sperm)
1.				
2.				
3.				

Cryopreservation was held in compliance with technologies applied according to Manufacturer's protocol.

Cryopreserved embryos/ oocytes / sperm/ ovarian tissue / testis or its epididymis which were preserved in _____

upon patient's written application were transferred

«____» _____ 20___. to _____

Written consent of Director of _____ was obtained.

Person in Charge for transporting

_____ _____

(Surname, First Name. Patronymic, y.b.) (Signature)

Embryologist

_____ _____

(Surname, First Name. Patronymic, y.b.) (Signature)

Director of Medical Center

_____

Authorized representative (by attorney)

«____» _____ 20___.

Seal here