BIO GENETICS CORPORATION®

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187 Mill Lane <> Mountainside, New Jersey 07092 <> 908-654-8836 <> 800-637-7776 <> Fax 908-232-2114

PHYSICIAN AUTHORIZATION FORM

FOR DIRECT RECIPIENT PURCHASE OF CRYOPRESERVED DONOR SPERM

This document is valid for a period of twelve (12) months from this effective date: ______________________________

I am referring and authorize (enter **Recipient's Name**) ____
to BioGenetics Corp. to obtain cryopreserved donor sperm for an Assisted Reproduction Treatment (ART).

I have informed the above named recipient of the risks, limitations and outcomes of current assisted reproduction procedures associated with the use of cryopreserved donor sperm.
The recipient was advised and has accepted to order the necessary number of cryopreserved donor specimen vial(s) as well as to be responsible for payment to BioGenetics prior to every delivery/shipment.

All specimen(s) obtained from BioGenetics are for the exclusive use of the recipient named in this referral.

All assisted reproduction procedures will be performed under my direction and supervision.

Print Physician Name: ____
First Middle Last Suffix

Facility Name: ____

Office Address: ____

City: ______________________________ State: ______________ Zip Code: ___________ Country: __________________

Telephone: ____ Fax: ____

Physician Signature: ____ Date: ______________________________

REMINDER

The following documents must be received by mail/fax at BioGenetics Corp. prior to the initial order placement or purchase of cryopreserved donor sperm.

The following two (2) documents must be submitted with your first (initial) order.

PROVIDER SERVICE AGREEMENT FOR CRYOPRESERVED DONOR SPERM
RECIPIENT ACKNOWLEDGEMENT AND CONSENT FOR THE THERAPEUTIC ASSISTED REPRODUCTION BY CRYOPRESERVED DONOR SPERM