BIOGENETICS CORPORATION

FDA Registered <> Licensed by New York State Department of Health<> Licensed by New Jersey Department of Health (CLIA)
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

License Number: _____ State Issued: _____

Facility Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Telephone: _____ Fax: _____

Email: _____ Contact Name: _____

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