International Identity (ID) Option Birth Registration Form

Shaded boxes (_____) must be filled in.

Congratulations! We have recently received a report of your pregnancy from the use of donor sperm from Fairfax Cryobank, Inc. (hereafter known as Cryobank), that had been obtained from _____ (Company Name). Since this pregnancy resulted from an Identity (ID) Options donor, as per the agreement originally signed at the time of your order, you **MUST** register the birth of your child with Cryobank in order for him/her at age 18 or older to receive Identifying Information about the donor. **Merely using semen from the Identity (ID) Option donor does not allow access to the Identifying Information. To ensure that the Donor's Identifying Information will be provided, you MUST complete the following information and return this registration form to Cryobank upon the birth of your child or up until they reach the age of 18. If you choose not to register your child, the donor will remain anonymous and your child will not be able to access identifying information once s/he reaches 18 or older.** The information provided below is confidential and will only be used when/if your child requests Identifying Information regarding the donor.

Parent information:

_____
Signature of Recipient

_____
City, Province, Country, Postal Code

_____
Printed Name (First / Surname)

(_____)_____
Daytime Phone Number

_____
Address

Physician who performed or oversaw the insemination or embryo transfer procedure:

_____
Printed Name

_____
Clinic name

_____
Address

_____
City, Province, Country, Postal Code

(_____)_____
Phone Number

Date of insemination or fresh embryo transfer that resulted in this pregnancy _____/___/_____
mm / dd / yyyy

Were embryos created and frozen for a future attempt at pregnancy? Yes No

Was this pregnancy a result of transfer of previously frozen embryos? Yes No

If Yes, when were they created? _____ /_____
mm / yyyy

Cryobank Donor #_____ Brand: ☐ FAIRFAX ☐ CLI

Offspring Information:

Offspring 1

_____
Name (First / Surname)

_____ _/____/_____
Date of Birth mm / dd / yyyy

Sex: [ ] Male [ ] Female

_____
Social Insurance Number or □ copy of birth certificate

Offspring 2 (if applicable)

_____
Name (First / Surname)

_____/_____/_____
Date of Birth mm / dd / yyyy

Sex: [ ] Male [ ] Female

_____
Social Insurance Number or □ copy of birth certificate

Return form to: Fairfax Cryobank, Inc.
Attn: Identity (ID) Option Program
3015 Williams Drive, Ste 110
Fairfax, VA 22031 USA

Office use only:
Date form received _____
Order/donor verified _____
Physician confirmed _____