

|                          |   |                         |
|--------------------------|---|-------------------------|
| DATE EFFECTIVE: 01/15/12 | <b>Fairfax Cryobank Specimen<br/>Complaint Form</b> | FORM: QAP.30k<br>REV: 0 |
|--------------------------|---|-------------------------|

**Must be completed by Physician's Office performing the procedure**

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| Complaint #:<br>Date Received:<br>FFX Use Only |
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Fairfax Cryobank is committed to providing accurate quality control on every semen specimen we produce. We stand behind our products with the following specimen standards: ICI and IUI (pre-washed) specimen standard minimum of 10 million TMC/vial. IVF specimen standard minimum of 5 million TMC/vial.

Our specimen quality standards for TMC are approximations due to variations in analytical methods and personnel among laboratories. We will take into consideration these variations between labs in determining if a specimen is eligible for a credit. Other terms of our specimen standard are: a) our thaw procedures, enclosed in each shipment, must be followed; b) specimen standards apply at the time of thaw and prior to any post thaw processing; c) specimens stored outside Fairfax Cryobank longer than sixty days are not eligible for credits; d) complaints must be submitted within ten business days of thawing; e) shipping costs are not refunded unless specimens arrive thawed; f) no credits if a pregnancy is achieved with a specimen; and g) our liability for any deficiency in specimen quality is limited to supplying a replacement specimen or cash refund, at our discretion.

If the specimen(s) you received did not meet our quality standard, please fax form to 703-698-3933. Your claim will be evaluated to determine if it qualifies for a refund of the cost of the specimen or a replacement of that specimen. **Claims cannot be considered unless this form is completed in its entirety. We may contact the under signed for verification of the information provided, please feel free to include the best time to reach the under signed. If you have any questions about completing this form, please call 800-338-8407.**

**ALL SECTIONS OF THIS FORM MUST BE COMPLETED**

|                    |                      |
|--------------------|----------------------|
| Invoice #:         | Clinic Name:         |
| Patient Name:      | Physician Name:      |
| Patient Account #: | Physician Account #: |

|                      |   |   |
|----------------------|---|---|
| Date Specimen rec'd: | Frozen upon arrival: <input type="checkbox"/> yes <input type="checkbox"/> no | Specimen Type: <input type="checkbox"/> ICI <input type="checkbox"/> IUI <input type="checkbox"/> IVF |
| Donor #:             | Specimen Date and Vial #:   |   |

Check here if specimen arrived thawed and stop completing form. Fax this form to the above fax number.

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| Thaw Date: |
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Thaw Procedure (check all that apply) Room Temp (\_\_\_\_#mins)  
Other (describe): \_\_\_\_\_

Was the specimen mixed before analysis? yes no  
 If yes, how? inverted several times with a pipette Vortex Other \_\_\_\_\_

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Post Thaw Information (Complete one form for each vial.)

Use the formula below to calculate the total motile cells per vial after thaw prior to any additional processing (if applicable) performed at your clinic:

|                             |   |                               |   |                                |
|-----------------------------|---|-------------------------------|---|--------------------------------|
| Total Conc _____ Million/ml | X | Total Motility _____ % / vial | X | Volume / vial _____ ml         |
| =                           |   |                               |   | Total Motile Cells _____ /vial |

Counting Method:  Hemocytometer     Makler     MicroCell     Cell-Vu     Standard count  
 CASA (last date of calibration) \_\_\_\_\_  
 Other (*describe*): \_\_\_\_\_

Motility Method:  room temperature slide     RT Makler     ~37°C slide  
 37°C Makler     CASA (last date of calibration) \_\_\_\_\_  
 estimated \_\_\_\_\_  counted \_\_\_\_\_  
 Other (*describe*): \_\_\_\_\_

Patient  was  was not    inseminated/had procedure performed following post thaw preparation of the specimen.  
 Patient is pregnant?  yes     no     too early to determine, Expected Pregnancy Test Date \_\_\_\_\_

Name of Staff Member who completed analysis above: \_\_\_\_\_

Physician Office Staff Member who completed complaint form and verified information above:

***I verify that the above information is accurate and the information listed above is reported prior to washing/further processing (additional processing prior to counting will render the specimen ineligible for a refund).***

Signature \_\_\_\_\_ Date \_\_\_\_\_ Best contact time \_\_\_\_\_

Printed Name \_\_\_\_\_ Contact Number: \_\_\_\_\_ Contact email: \_\_\_\_\_

Comments:  If no additional comments, check this section is N/A

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