



COMPANY CONFIDENTIAL AND PROPRIETARY

DATE EFFECTIVE: 07/06/09	<b>Identity (ID) Option Birth Registration Form</b>	FORM: ACQ.20ad REV: B
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Congratulations! We have recently received a pregnancy report from your order # \_\_\_\_\_. Since this pregnancy is resulting from an Identity (ID) Options donor, as per the agreement originally signed at time of order, you **MUST** register the birth of your child with GIVF Cryobanks in order for him/her to receive Identifying Information at age 18. **Merely using semen from the ID Options 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 GIVF Cryobanks 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:**

Printed Name (Both partners if applicable)

\_\_\_\_\_

Partner Signatures \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ph# \_\_\_\_\_

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

Name \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ph# \_\_\_\_\_



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Date of insemination or fresh embryo transfer that resulted in this pregnancy \_\_\_\_\_

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

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

If Yes, when were they created? (MM/YYYY) \_\_\_\_\_

Donor # \_\_\_\_\_

( ) Cryogenic Laboratories, Inc.

( ) Fairfax Cryobank

**Offspring Information:**

Name (s) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex: [ ] Male [ ] Female

Social Security Number (s) \_\_\_\_\_

**Return form to:** GIVF Cryobanks  
 Attn: Identity (ID) Option Program  
 3015 Williams Dr. Suite 110  
 Fairfax, VA 22031

*Office use only:*  
 Date form received \_\_\_\_\_  
 Order/donor verified \_\_\_\_\_  
 Physician confirmed \_\_\_\_\_