



DATE EFFECTIVE: 02/22/10	<b>Photo Match Request Form</b>	<b>FORM: DIS.40h</b> <b>REV: F.01</b>
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To obtain photo assistance in donor selection, please complete **OPTION 1 OR OPTION 2** of this form. If both options are completed only option 1 will be performed. Please note only donors from the Fairfax Cryobank and Fairfax Cryobank Doctorate categories have photos available for photo matching purposes. Donors indicated with a Fam. Sol.@ on the Register do not have photos available for photo matching. The fee for photo assisted donor matching is \$60.00. Please provide two color photos, a close up frontal and side view, of the person to whom you desire a donor match and label all photos with your name. Results will be completed within 3-5 business days of receipt by Fairfax Cryobank. Rush results will be charged the current Fairfax Cryobank rush fee. Mail this form along with the color photos to:

**Fairfax Cryobank, ATTN: Photo Match Service, 3015 Williams Drive, Suite 110, Fairfax, VA 22031**

**OPTION 1**

Review Fairfax Cryobank's current Donor Selection Register and narrow your choices to eight donors or less. Please be sure to check donor availability on the Register. Your photographs will be compared with photographs of the donors you selected and the donors ranked in the order of highest to lowest degree of resemblance to the photographs provided.

(1) # \_\_\_\_\_ (3) # \_\_\_\_\_ (5) # \_\_\_\_\_ (7) # \_\_\_\_\_  
 (2) # \_\_\_\_\_ (4) # \_\_\_\_\_ (6) # \_\_\_\_\_ (8) # \_\_\_\_\_

**OPTION 2**

Complete the following respective items that you feel are important. Any information listed below that you feel is not important should not be completed. Your photographs will be compared with photographs of donors currently available to determine a short list of recommended donors which seem to have facial characteristics similar to that of the individual used for matching. Donors will be ranked in order of highest to lowest degree of resemblance to the photographs and information provided.

**Race** (Caucasian, Black, Asian, Other) \_\_\_\_\_

**Ethnic Preferences** \_\_\_\_\_

**Jewish** [ ] Yes [ ] No

**Specimen prep** [ ] IUI [ ] ICI [ ] IUI or ICI

Please list the order of importance next to each applicable item and circle the appropriate information

<b>Height (ft-in)</b>	_____	5-9	5-10 to 6-0	6-0 to 6-2	6-2 to 6-4	6-4
<b>Weight (lbs)</b>	_____	150	150 to 170	170 to 190	190 to 210	210
<b>Skin tone</b>	_____	light	med-light	medium	med-dark	dark
<b>Eye color</b>	_____	brown	blue	hazel	green	
<b>Hair color</b>	_____	blond	brown	black	red	

Please list any other characteristics that you feel are important \_\_\_\_\_

**METHOD OF PAYMENT** (personal checks or cash not accepted)

Card type:      Visa      Mastercard      American Express      Discover

Card number: \_\_\_\_\_

Name on the card: \_\_\_\_\_      Expiration date: \_\_\_\_\_



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**RESULTS**

Check the appropriate box for the preferred method to receive photo match results

- US Mail   
 FedEx overnight (\$30.00)   
 Fax# \_\_\_\_\_  
 E-mail \_\_\_\_\_

Please return photos  yes     no\*

\*Please note if photos are returned follow up questions cannot be answered in most cases. If results are faxed or e-mailed, photos will be returned via US Postal Service. International FedEx Priority rate is \$60.00 USD.

**TERMS AND CONDITIONS**

We are specifically requesting that Fairfax Cryobank provide photo matching assistance and make a recommendation of a donor for final selection by us.

We understand that photo assisted donor matching by Fairfax Cryobank is a recommendation of a donor and that the final decision of donor selection is solely by ourselves. Fairfax Cryobank will make a reasonable effort to photo match a donor based on the information and photos provided by us. Photo matching is a subjective process and results may be inconsistent based on the individual performing the match.

We understand and accept that Fairfax Cryobank and the Genetics & IVF Institute, its management, physicians, laboratory directors, and other personnel do not assume responsibility or liability for the accuracy of photo matching or the physical, mental, or other characteristics of any child or children born as a result of the use of any donor from Fairfax Cryobank.

This represents the entire agreement between us and Fairfax Cryobank concerning donor matching; that there are no understandings, agreements, or representations other than as herein set forth, and we agree to all the terms, conditions and statements described in this document.

_____	_____
Name (PRINT)	Partner Name (PRINT) (If applicable)
_____	_____
Signature	Partner Signature (If applicable)
_____	_____
Date	Date

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_ HOME: \_\_\_\_\_ E-MAIL \_\_\_\_\_

**Fairfax Cryobank Use Only**

Date received \_\_\_\_\_      Evaluated by \_\_\_\_\_      Date results sent \_\_\_\_\_