

Further Processing of Cryo-Conserved Sperm

Client Name: Personal ID: Address:	Identification ID: passport: other: Verified by: <div style="text-align: center; font-size: small;"> ARLETA representative stamp and signature (ARLETA, Centrum reprodukčního zdraví) </div> Date: <div style="text-align: right; font-size: x-small;">(date of identification)</div>
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1. NOTICE

Dear Sir,

we would hereby like to notify you, that, on, your paid-up storage period for frozen sperm ends.

Please, select one of the options provided below (1. or 2.) by clearly checking the adjacent box. Please send the filled-in and signed form by post to the following adress: ARLETA IVF, Komenského 702, 517 41 Kostelec nad Orlicí, Czech Republic.

<input type="checkbox"/> 1. I hereby request that my cryoconserved sperm continues to be kept in storage in the ARLETA Reproductive Health Center laboratory, as I remain interested in its potential future use. I am aware that the storage of sperm is subject to an annual fee of 65 EUR. The fee is payable in cash at our front desk, or by bank transfer into the following account: <table style="width: 100%; font-size: small;"> <tr> <td style="width: 30%;">Number of bank account:</td> <td>430464040297/0100</td> </tr> <tr> <td>IBAN kod:</td> <td>CZ6701000000430464040297</td> </tr> <tr> <td>SWIFT:</td> <td>KOMBCZPPXXX</td> </tr> <tr> <td>Name of the clinic:</td> <td>Arleta IVF, s.r.o.</td> </tr> <tr> <td>Name of the bank:</td> <td>Komerční banka</td> </tr> <tr> <td>Address of the bank:</td> <td>Palackého náměstí 22, Kostelec nad Orlicí 517 41</td> </tr> </table>	Number of bank account:	430464040297/0100	IBAN kod:	CZ6701000000430464040297	SWIFT:	KOMBCZPPXXX	Name of the clinic:	Arleta IVF, s.r.o.	Name of the bank:	Komerční banka	Address of the bank:	Palackého náměstí 22, Kostelec nad Orlicí 517 41
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<input type="checkbox"/> 2. I hereby request my sperm to be destroyed, as I am not interested in its future use. I am aware that my signature must be notarized. Or else this form must be signed in your personal presence at the ARLETA Reproductive Health Center front desk, where your signature will be verified against your identity documents by our staff.												

2. CONSENT

I hereby declare:

- to possess legal capacity, and that my legal capacity has not been limited.
- to have understood the information provided to me, to have had the opportunity to ask questions, and that such questions, if any, have been answered to my satisfaction.
- in case of further storage (option 1) I will promptly and in written form inform the company about any changes (address, phone number...).
- all information I supplied to be, to the best of my knowledge, complete and true.

In Kostelec nad Orlicí on: Client signature