

CONSENT TO DONATE SEMEN (SPERM)

First Name:	Middle Name:	Last Name:
Current address:		
City:	State:	ZIP Code:
Phone (Day):	Phone (Eve):	Email:
Signature of Semen Donor		Date
<p>I have knowingly and willingly agreed to serve as a semen donor. I have been informed of the nature of sperm banking with regard to the screening and use of my donated semen. At this, to the best of my knowledge I am free of genetic and infectious diseases such as AIDS.</p> <p>I agree and understand that I will be screened/tested initially, periodically (about every 3 months), and six months after the semen specimen is donated for all required and recommended diseases, infectious agents, sexually transmitted diseases or any other blood test required by Fertility Center of California, FCC. I will comply with the advice to abstain from ejaculation for at least two days prior to each semen donation.</p> <p>I agree and understand that my semen may be used for therapeutic purposes and that my identity will not be revealed. I promise to keep strict confidentiality in my role as a donor and will not provide semen sample for use if there is any reason now or in the future to suspect that I may have genetic, sexual, or infectious diseases. I likewise verify that the accompanying information used in the process of my selection as a donor is valid and true to the best of my knowledge. I will collect and handle all samples provided to the laboratory according to the specifications of FCC.</p> <p>I agree not to attempt to find out the identity of the person for whom I am donating semen specimens and I understand that my own identity will be kept in strictest confidence. I waive and disclaim any rights to offspring born of artificial insemination and will not attempt to discover the identity of persons who receive the specimen. Following acceptance, I should be compensated \$65.00 per acceptable sample as a reimbursement for transportation, inconvenience and other expenses incurred in providing the donated semen sample.</p> <p>I farther willingly and voluntarily consent to and authorize FCC to draw my blood and test it as required by Fertility Center of California protocols including but not limited to AIDS-related infectious agents such as the Human Immunodeficiency Virus (HIV). I have now been told by FCC that prior to such testing, I may wish to consider counseling at my expense regarding the meaning of positive test results and their reporting. The anti-HIV antibodies test means that your blood will be tested for antibodies to HIV, causative agent for AIDS and shows whether you have been exposed to the virus. Antibodies are produced by the white cells in the body in response to an infection. In the event the test result is positive, you will be urged to contact a private physician at your own expense, County or State Department of Health Services, local Medical Societies, or alternative test sites for appropriate counseling. FCC is required to release your name to the California Department of Health or other County Health agencies if your test result is positive for HIV.</p> <p>I have read and understood this notice and its contents, and consent for AIDS-related blood testing. I also understand that I have the right to request and receive a copy of this consent/authorization. A photocopy of this form will be as valid as the original.</p>		
Signature of Semen Donor		Date

