UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

LABORATORY OF ASSISTED REPRODUCTIVE TECHNOLOGIES
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1.2 CONSENT FOR FROZEN OOCYTE DONATION TO RESERACH

This agreement is made between _____ (collectively, the "Patient") and the Michigan Medicine (MM) Center for Reproductive Medicine (CRM).

Currently, the Patient has **total** _____ (number) cryopreserved egg(s) stored at the Michigan Medicine. The Patient now requests that **ALL** egg(s) be donated to the research.

Donating eggs for research may not be possible or may be restricted by law. While efforts will be made to abide by your wishes, no guarantees can be given that eggs will be used for research. In these instances, if after **two** years no recipient or research project can be found, or your eggs are not eligible, your eggs may be destroyed and discarded by the lab in accordance with laboratory procedures and applicable laws or be utilized for internal quality control and training purpose before being destroyed and discarded.

The Patient acknowledges and agrees that once the egg(s) are donated, the decision is final and cannot be revoked. The Patient assumes the full responsibility for her/his decision to dispose of the eggs.

The Patient, their children, heirs, representatives and assigns, (collectively, the "Indemnifying Parties") agree to release individually and collectively the Michigan Medicine and their respective employees, directors, officers, agents, physicians and representatives (collectively, the "MM Parties") from any claims any Indemnifying Parties may have against such MM Parties relating to the safekeeping or disposal of the eggs. Indemnifying Parties further agree to indemnify, defend and hold harmless each of and all of the MM Parties from any liabilities, costs, claims or actions of any sort (including, but not in any way limited to attorneys' fees and fines) which might be brought, charged or assessed against any or all of the MM Parties with regard to the maintenance or disposal of the eggs.

This consent must be signed in person in front of witness at the CRM or be witnessed by a Notary.

Patient _____(Print Name) _____ (Signature)

_____(Date of Birth) _____ (Date)

Legal Guardian _____ *(Print Name)* _____ *(Date of Birth)*
(If the Patient <18 at the time of signature)

_____*(Signature)* _____ *(Date)*

_____

CRM Witness Signature, Date & Time

For Notary ⇒