the women's
the royal women's hospital

Andrology Department

The Royal Women's Hospital
C/- Locked Bag 300
Parkville VIC 3052
Phone: 03 8345 3992
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REQUEST FOR TRANSFER OF FROZEN SPERM

I, _____ (Full name)

_____/_____/_____ (Date of birth)

of _____

_____ (Address)

_____ (Telephone) _____ (Mobile)

hereby authorise the Andrology Unit of The Royal Women's Hospital to arrange the transfer of (please indicate *one*:) **all** ***/*** _____ **(number)** frozen sperm straws/vials **FROM** _____ (clinic name) **TO**:

Clinic: _____

Address: _____

_____

Contact name: _____ Tel: _____

In making this request, I absolve The Royal Women's Hospital and any of its Servants and Agents, and in particular, the staff of the Andrology Unit, of any liability for loss of, or damage to my sperm during the transfer process. I also agree to pay for the cost of the transfer of my sperm.

Signed: _____ Dated: / /

Witness: _____ Dated: / /

Witness Full name: _____