

EMBRYO DISPOSITION REQUEST

PATIENT INFORMATION:

PATIENT NAME: ONYIAGHA PHILOMINA 0
LAST FIRST MI

PARTNER NAME: ONYIAGHA CHRISTIAN U
LAST FIRST MI

ADDRESS: 11698 S. LAUREL DR. APT 4C LAUREL MD 20708
STREET CITY/STATE/ZIP

PHONE: _____ PHONE: 2406588777
HOME WORK/MOBILE

PATIENT VERIFICATION:

The physician in charge of my treatment at time of my egg retrieval procedure was
 Dr. OLUYEMISI FAMYINA.

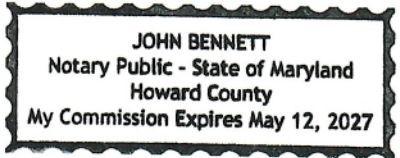
PATIENT REQUEST: CLEARLY INDICATE YOUR INSTRUCTIONS FOR DISPOSITION PREFERENCE

- I/ We wish to have all my/our embryo(s) (In the case of PGS, all normal and abnormal embryo(s)) discarded in accordance with applicable laws and regulations.
- I/We wish to have my/our embryo(s) transferred to another storage facility. I/we will complete the ALL the required documents, including the instructions regarding Transfer of Biological Materials form and any state health department documents, to arrange for transfer *with a minimum of one month notice*.
- I/We wish to donate the embryo(s) to Montgomery Fertility Center and Conception Center, intending for another patient's use:
 circle one: ANONYMOUSLY or DIRECTED (additional documents required) for directed donation _____
- I/We wish to donate my/our embryo(s) to Montgomery Fertility Center and Conception Center, intending for research use only.
- I/We wish to dispose my/our embryo(s) in another way (please specify very clearly and write clearly):

[Signature] 1/23/2024
 PATIENT SIGNATURE DATE

[Signature] 1/23/2024
 PARTNER SIGNATURE DATE
 (Indicate N/A if this signature is not applicable and initial)

[Signature] 1/23/24
 NOTARY PUBLIC SIGNATURE & DATE - SEAL



[Signature] MD 3-1-2024
 PHYSICIAN SIGNATURE DATE

MFC & C.C USE ONLY:

Received by Billing: _____ Inventory Updated: _____
 Received by Lab: _____ Execution Date: _____