MONTGOMERY FERTILITY CENTER

EMBRYO DISPOSITION REQUEST

PATIENT INFORMATION:

PATIENT NAME: ONYIAGHA (LAST) PHILOMINA (FIRST) O (MI)

PARTNER NAME: ONYIAGHA (LAST) CHRISTIAN (FIRST) U (MI)

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

PHONE: _____ (HOME) PHONE: 2405588777 (WORK/MOBILE)

PATIENT VERIFICATION:

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

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):

_____

1/23/2024
PATIENT SIGNATURE **DATE**

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

1/23/24
NOATRY PUBLIC SIGNATURE & DATE - SEAL

JOHN BENNETT
Notary Public - State of Maryland
Howard County
My Commission Expires May 12, 2027

3-1-2024
PHYSICIAN SIGNATURE **DATE**

MFC & C.C USE ONLY:
Received by Billing: _____ Inventory Updated: _____
Received by Lab: _____ Execution Date: _____