

University Women's Healthcare-Fertility Center  
401 E. Chestnut, Ste. 410 - Louisville, KY 40202  
Tel. 502-271-5846; Fax 502-271-5984

---

**FROZEN SPERM DISPOSITION FORM**

---

I, \_\_\_\_\_ (Client Depositor)

request and consent to the disposal of all my frozen:

- sperm (semen or testicular sample(s) )  
 donor sperm

following the policies and procedures established by the Fertility Center.

_____ Signature (Client Depositor)	_____ Date
_____ Signature (Client Depositor)	_____ Date
_____ Guardian (if Client Depositor is a minor)	_____ Date
_____ Signature (Fertility Center Witness or Notary Public)	_____ Date

Return this form to: Embryology Laboratory  
Fertility Center  
401 East Chestnut Street  
Suite 410  
Louisville, KY 40202

---

To be completed by Embryology Laboratory

Date(s) frozen \_\_\_\_\_ # Straws \_\_\_\_\_ #vials \_\_\_\_\_

**Patient/sample ID Confirmation:**

Straw(s)/vial(s) labeled as: \_\_\_\_\_ Tech \_\_\_\_\_

Date of sperm thawing and disposal \_\_\_\_\_ Tech \_\_\_\_\_