Are you using a donated:

☐ Donated Egg ☐ Donated Sperm ☐ Donated Embryo

FDA DONOR ELIGIBILTY FORM REQUIRED

Is this a Surrogacy or an Adoption? ☐ **YES** If YES:

PLEASE NOTE: A different agreement and informed consent is required from the birth carrier. Please contact our Customer Service line for additional information at (800) 786-7235 option 1 if you have not received the Birth Carrier Enrollment Packet.

Please check all that apply: ☐ Singleton ☐ Twins (2 kits) ☐ Triplets (3 kits) ☐ Quads (4 kits) ☐ Adoption ☐ Surrogate

MOTHER or PARENT CONTACT INFORMATION:	FATHER or CO-PARENT CONTACT INFORMATION:
Full Legal Name:	Full Legal Name:
Social Security #:	Social Security #:
Date of Birth:	Date of Birth:
Address:	Address:
City/ State:	City/ State:
Zip/Country:	Zip/Country:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Due Date:	

PROVIDE YOUR INTERNATIONAL MAILING ADDRESS HERE: (if applicable)	THIRD CONTACT INFORMATION (Optional):
Full Legal Name:	Full Legal Name:
Address:	Address:
City/ State:	City/ State:
Zip/Country:	Zip/Country:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	Email:

PRACTICE/DOCTOR INFORMATION	HOSPITAL INFORMATION
Practice Name:	Hospital Name
Obstetrician/Midwife:	Address:
Address:	City/ State:
City/ State:	Zip/Country:
Zip/Country:	Phone:
Phone:	Fax:
Fax:	

Where you Referred by a Friend or Family Member?

PLEASE LIST REFERRER'S FIRST AND LAST NAME: _____

CLIENT AGREEMENT AND INFORMED CONSENT FOR UMBILICAL CORD BLOOD AND CORD TISSUE SERVICES

Client Agreement and Informed Consent for Umbilical Cord Blood and Cord Tissue Services (the "Contract") is between Cryo-Cell International ("Cryo-Cell") and parent(s) or legal guardian(s) ("Client(s)"). Cryo-Cell's Service covers two distinct offerings, which may be purchased separately or together: (a) cord blood stem cell collection, processing, testing and storage ("Umbilical Cord Blood Service") and/or (b) cord tissue collection, processing and storage ("Cord Tissue Service") either alone or collectively, the ("Service or Services"). This Contract provides Parent Instructions for the collection, testing, processing, cryopreservation and storage of the cord blood stem cells and/or cord tissue either alone or collectively, ("baby's stem cells") from the umbilical cord after the birth of the child ("Child"). These instructions must be read and followed. Client must execute the Contract along with the attached forms including; this Enrollment Form with Cryo-Cell & Client Responsibilities, Authorization to Collect Cord Blood and/or Cord Tissue and Birth Mother's Blood Release from Liability; Health History Questionnaire and Informed Consent, Client Information form, Health Care Provider form, and Birth Carrier Enrollment Packet (if applicable); Cord Blood and/or Cord Tissue Collection Services Purchased and Payment Information.

CRYO-CELL & CLIENT RESPONSIBILITIES

Cryo-Cell is responsible for providing a collection kit, which includes client instructions and collection instructions for the healthcare provider expected to perform the collection. Cryo-Cell will indefinitely maintain linkage between the mother and baby to the cord blood and/or cord tissue stored stem cells. Client is responsible for following the provided Parent Instructions, and informing their healthcare provider that collection of the baby's stem cells is requested at delivery. Client must bring the collection kit to the hospital or birthing center at the time she presents herself for delivery of the baby. Client will provide the Healthcare Provider Instructions to their healthcare provider and agrees to inform them to collect birth mother's blood upon admission and prior to any IV fluids or blood products administered, collect the umbilical cord blood and/or cord tissue, obtain a physician's physical assessment of the biological mother and baby and complete the associated documentation provided in the collection kit, according to the terms of this Contract. Client will authorize Cryo-Cell to test birth mother's blood and cord blood/tissue specimens according to the Informed Consent. If any complications occur during birth, your healthcare provider may elect not to collect the baby's cord blood and/or cord tissue. Cryo-Cell utilizes a medical courier service to pick up your specimen(s) at your hospital room and deliver it to Cryo-Cell's facility at a flat rate fee.[1] Immediately after delivery client/designee will call Cryo-Cell International 24/7 at 1-800-786-7235, to arrange for the transport of your specimen(s). The specimen(s) should remain with the client in a secure environment at all times and kept at room temperature prior to pick-up. The medical courier retrieves the collection kit from the hospital or birthing center and delivers the specimen(s) to Cryo-Cell utilizing the optimal transportation method to get your baby's stem cells to Cryo-Cell's processing laboratory as quickly and safely as possible. Specimens should be received in the Cryo-Cell laboratory within 72 hours of the time of collection for optimal processing results. Information related to the infant donor and the infant donor's family shall remain confidential and is only available for review by individuals designated by Cryo-Cell International or by national authorities to evaluate the Cord Blood Bank.

Cryo-Cell will process, test, cryopreserve and store the baby's stem cells in accordance with Cryo-Cell's approved processing protocols. Some of the plasma and red blood cells that remain after processing and cryopreservation of the baby's stem cells and maternal blood will be stored for future testing for family, should they be needed. All waste products become the property of Cryo-Cell. Cryo-Cell may choose not to process and/or store the baby's stem cells if the specimen does not meet certain Cryo-Cell requirements including, but not limited to: low cell yield of the cord blood unit, age of cord blood or cord tissue stem cells, improper collection of the baby's stem cells, improper handling or shipment of the baby's stem cells (i.e., not in conformance with Cryo-Cell protocol), or if the specimens test positive for HIV. Cryo-Cell will notify Client regarding the planned disposition of the baby's stem cells if there are any problems that would prevent processing, testing cryopreservation and storage.

Due to the nature of the collection, all specimens can vary in suitability of their use. Variations can include, but are not limited to: bacterial contamination, not having appropriate infectious disease test results, health history of the client, birth carrier and/or baby's physical examination, cell count too low for treatment of certain diseases. Cryo-Cell cannot predict disease test results and cell count requirements of cord blood unit at time of need. Requirements change and vary depending on medical condition and clinical trial criteria.

[1] The cost of our medical courier service is $150 in the Continental USA, and $200 in AK, HI and PR. International clients must choose a courier service, and will be billed directly by their selected courier.

In the event that the stem cells are requested for transplantation or infusion, the treating physician will determine the suitability of their use with a report provided by Cryo-Cell containing all the available test results.

Compliance to the Parent Instructions provided, which includes kit handling and packaging instructions is required, as variance to them may affect the suitability of the specimen for use. This can include, but are not limited to: incomplete forms-Health History and Informed Consent, Client Information, Healthcare Provider, or Client Agreement; storage of the kit outside the required temperature; improper packaging of the cord blood or the maternal tubes; insufficient volume of cord blood or maternal blood; not using provided collection supplies; unlabeled cord blood or maternal blood tubes; not returning specimens required for processing and/or testing. In the case of an international shipment or when an emergency kit is couriered, Client will be responsible for the medical courier charges. Cryo-Cell will send Client a certificate of preservation to confirm that the baby's stem cells have been successfully processed and stored.

Client is responsible for completing and returning all of the associated documentation provided with the collection kit. Not having the required documents completed and returned to Cryo-Cell may also affect the suitableness of the specimen depending on requirements at time of need. The treating physician will be notified of any missing documents or information and they will determine suitability of their use.

In the event that follow up information is necessary, I authorize Cryo-Cell to contact the collecting physician or authorized designee to review the birth mother/ Non-Client Birth Carrier and child's medical records at a later date. This review is limited to information necessary to complete or clarify any paperwork required to meet Cryo-Cell transplant release criteria. Cryo-Cell acknowledges the confidential nature of the information provided by Client and, if different from the Client, the birth mother of the Child, in connection with this Agreement and Cryo-Cell agrees to use its reasonable best efforts to maintain the confidentiality of the information except as required by law or as permitted by this Agreement. Client and, if different, the birth carrier of the Child hereby agrees to the release of information with regard to such person or the Child and related to the services performed hereunder, to the hospital, laboratory, or collector providing these services to the Client or, if different, the birth carrier of the Child. Please inform us at 800-786-7235 if at any time there is an update to the health of your baby that should be maintained with their records.

Client is responsible for payment of all fees. If Client cancels Cryo-Cell's Service(s) prior to delivery, Client must notify Cryo-Cell and mail the collection kit back within 2 weeks of notification to avoid a $150 non-refundable cancellation fee. This fee will automatically be charged 30-45 days after the due date. Cryo-Cell is not responsible for reimbursing Client for fees that Client's physician, midwife or other medical professional may charge for the collection of the baby's stem cells. If the client enrolls in the Cord Blood Service only, the client agrees that in the event cord tissue is provided along with the umbilical cord blood, the cord tissue may be disposed of or used for research & development purposes by Cryo-Cell.

In the event that the baby's stem cells are requested for transplant or other treatments, contact Cryo-Cell International at (800)-786-7235. Cryo-Cell requires a written authorization by Child(s)/Legal Guardian(s) to release the baby's stem cells as well as a written request from a physician qualified to perform a stem cell transplant or other treatments (that must be associated with an FDA or equivalent approved protocol). The Specimens(s) will be available to the requesting physician within thirty business days after the request is made to Cryo-Cell, as long as all other conditions required for the release of the specimen(s) are met by the Client and/or Physician according to FDA (or equivalent), Cryo-Cell's accreditation agencies and other applicable federal and state regulations. Please note that the physician makes the ultimate determination as to the course of medical treatments. Following the current consent to release form provided by Cryo-Cell to client, Cryo-Cell's receipt of the authorization and request, Cryo-Cell and/or the treating facility will conduct appropriate testing on the baby's stem cells and ship the baby's stem cells to the identified facility. Client is responsible for all shipping expenses and required testing for transplant.

Client understands and agrees that Cryo-Cell accepts the baby's stem cells from Client in Client's capacity as Child's legal guardian. Absent termination of this Contract, Cryo-Cell has no rights to the baby's stem cells. Cryo-Cell shall be entitled to rely on instructions from the designated parent/guardian until Child turns eighteen, in connection with any disposition of the baby's stem cells, fees, change in contact information and any other requirement for Services under the Contract. Client is responsible for notifying Cryo-Cell Customer Service of changes to payment information

while this Contract is in effect. In the event that Client wishes to assign his/her rights and obligations under this Contract to another Party, this new Party must sign a new Agreement to confirm their understanding and Contract of the terms and conditions of this Service. In the event that a Client whose account is current wishes to discontinue the Service(s) before the Child turns eighteen, Client may so inform Cryo-Cell, in writing by signing a Discontinued Storage Letter which will be provided by Cryo-Cell. In such instance, all ownership rights to baby's stem cells will transfer to Cryo-Cell. Requests must be on an approved document, provided by Cryo-Cell, detailing Client's account information with the instructions for disposal or donation to research. The letter is then sent to the requesting parent(s) or legal guardian(s) and requires signature from the responsible party(s) that is bound to this Client Agreement and Informed Consent. After the Child turns eighteen, request to discontinue the Service must come from Child and Child is required to sign a Discontinued Storage Letter.

In the event that a Client, whose account is current, wishes to transfer the baby's stem cells before Child turns eighteen to another FDA registered storage facility; an appropriate entity for research; or donation to a public cord blood bank, Client may contact Cryo-Cell at (800)-786-7235. Cryo-Cell will communicate transfer requirements to Client. Such requirements include the following: (a) Client's identity must be verified, (b) Client must identify an entity that is able to receive the baby's stem cells in compliance with all regulations and requirements, (c) Signed Consent for Release, (d) receiving entity must complete all Cryo-Cell-required documentation in support of the transfer, (e) Client must pay a transfer fee that reimburses Cryo-Cell for all expenses in connection with the transfer, including costs to complete documents required to comply with regulations and costs to retrieve, package and ship the baby's stem cells, and (f) Client and receiving entity must agree to hold Cryo- Cell harmless for any losses or damages in connection with the transferred baby's stem cells. Please note, upon transfer of the cord blood unit, the Cryo-Cell Payment Guarantee will no longer apply nor do FACT and AABB accreditation status transfer with the product. If upon partial transfer of specimens, any specimen(s) remaining stored, the annual storage fee will continue to apply.

Starting on the child's eighteenth birthday, the Child directs the release and use of the baby's stem cells. Client agrees that on and after the child's eighteenth birthday, the retrieval and use of the baby's stem cells shall be at the sole direction of the Child and that Client has no further right or power to direct the release, use or discontinue storage of the baby's stem cells. Effective as of the Child's eighteenth birthday, Client hereby releases and renounces in favor of the Child any and all right, title or interest that you may have in or relating to the baby's stem cells. Client may continue to pay the annual storage fees for the benefit of Child.

Cryo-Cell may terminate this Contract at any time if any payment due to Cryo-Cell is not timely paid and such failure to pay is not cured within sixty (60) days after receipt of notice from Cryo-Cell to Client of failure to pay. In the event of termination for nonpayment, Cryo-Cell will not reimburse any fees paid to Cryo-Cell by Client and all ownership rights to the baby's stem cells will transfer to Cryo-Cell. Upon termination or expiration of the term of this Contract, Client agrees: (a) to pay all outstanding fees due to Cryo-Cell (b) to release all rights and waive all claims against Cryo-Cell, its Affiliates and the respective agents, employees, directors, shareholders, representatives, and consultants of Cryo-Cell with regard to this Contract, the services provided hereunder and the baby's stem cells; (c) that Cryo-Cell shall have no further liability or obligations to Client with regard to the baby's stem cells or otherwise, following termination or expiration and (d) that all ownership rights to the baby's stem cells will transfer to Cryo-Cell.

This Contract will be governed by and construed in accordance with the laws of the State of Florida, without giving effect to conflict of laws, rules or principles. This Contract has been prepared in the English language and the English language shall control its interpretation. All questions, disputes or differences which may arise between the Parties to this Contract shall, if such questions, disputes or differences cannot be amicably resolved by the Parties, be referred to arbitration to be held in Pinellas County, Florida in accordance with the Commercial Arbitration Rules of the American Arbitration Association, which rules are deemed to be incorporated by reference into this Section. The arbitrators' decision shall be final and binding upon the Parties and shall provide the sole and exclusive remedies of the Parties. Judgment upon any award rendered by the arbitrator may be entered in any court having jurisdiction in Pinellas. Application may be made to such court for judicial acceptance of the award or orders of enforcement.

Client understands that both the Service and the eventual transplantation or other medical procedures that may be used in connection with the baby's stem cells involve new techniques and procedures, and that, except for the limited rights conferred pursuant to the Cryo-Cell Payment Guarantee there is no guarantee or assurance of a successful outcome in the event that the cord blood or cord tissue unit is used. Once the client requests the unit and the unit is shipped from Cryo-Cell, client agrees to release Cryo-Cell from any and all liability, notwithstanding the

Cryo-Cell Payment Guarantee. Please note that the Cryo-Cell Payment Guarantee does not apply to the Cord Tissue Service. Cryo-Cell makes no representations or warranties with respect to the success of the collection, transportation, testing, processing, cryopreservation or storage process independent of the limited rights conferred by the Cryo-Cell Payment Guarantee.

In consideration of the opportunity to use Cryo-Cell's Service(s), Client understands and agrees that, except for the potential for a payment under the Cryo-Cell Payment Guarantee for the Umbilical Cord Blood Service and only in circumstances where the cord blood unit is required for transplantation, Cryo-Cell accepts no liability for any breach of its obligations or other acts or omissions. Client hereby releases Cryo-Cell and its officers, directors, employees, consultants, agents, affiliates, successors and assigns from any and all other liability for any and all loss, harm, damage or claim of any kind in connection with Cryo-Cell's Services. Without in any way limiting the preceding, Client hereby specifically releases Cryo-Cell from any and all liability associated with the loss or damage to the Cord Blood, Cord Tissue and/or Birth Mother's Blood while in transit. Client understands and agrees that by this release Client is giving up certain rights Client might otherwise have, now, or in the future to sue or otherwise seek monetary damages or other relief against
Cryo-Cell for any reason relating to the Services other than rights that Client may have under the Cryo-Cell Payment Guarantee, if any.

At enrollment, Client must choose from the plans available: the Processing method; and the Annual Storage Plan; the 18-Year Storage Plan; or the Lifetime Storage Plan when completing the Services Purchased section of the Contract. If the 18-Year Storage Plan or the Lifetime Plan is selected, the Contract, plan selected and its guarantee will transfer to the child upon the child's eighteenth birthday and the child will have full rights to their specimen.

If the Annual Storage Plan is selected on the Services Purchased section of the Contract, upon the Child's eighteenth birthday, Client may continue to pay storage fees for the benefit of Child. Cryo-Cell International may change the annual storage fee from time to time by providing written notice to the client(s). This Contract may be cancelled by Client's written request at any time, regardless of whether Child is still a minor or reaches the age of 18. When Child has reached the age of 18, Child has ownership claims to the baby's stem cells; however, since Cryo-Cell does not have a contractual relationship with Child, Cryo-Cell will rely on Client's representation that Client is acting on behalf of Child and will honor any request for cancellation that is made after the child turns 18.

Samples from the birth carrier/genetic mother and/or infant donors will be collected for communicable disease and genetic disease testing, HLA typing, and/or other testing, as applicable. Cryo-Cell International is required to notify the birth carrier/genetic mother or her responsible physician and governmental agencies when required of positive or indeterminate communicable disease or genetic test results.

AUTHORIZATION TO COLLECT UMBILICAL CORD BLOOD AND/OR CORD TISSUE AND BIRTH MOTHER'S BLOOD; RELEASE FROM LIABILITY

The undersigned is participating in the Cryo-Cell Umbilical Cord Blood and/or Cord Tissue Service(s). The service(s) requires the collection of a sample of the Mother's blood or in the case of adoption/surrogacy on the Birth Carrier and Genetic Mother if available and the collection of the Umbilical Cord Blood Specimen and/or Cord Tissue Specimen at the time of birth of the Child. The collection procedure is outlined in the Umbilical Cord Blood and Cord Tissue Collection Instructions. Client understands there are alternative options for storing the baby's umbilical cord blood, such as storage for public use or research. Consent is hereby granted by the undersigned to the medical professionals attending the birth to perform these collections.

The undersigned acknowledges that complications may occur during delivery which could prevent or impede the collection of the Umbilical Cord Blood and/or Cord Tissue Specimen or produce an inadequate Specimen(s) collection. I understand and acknowledge that my caregiver's medical judgment to collect or not collect the Specimen(s) shall be absolute and final. I understand my health and the health of my baby are the number one priority.

CLIENT AGREEMENT AND INFORMED CONSENT FOR UMBILICAL CORD BLOOD AND CORD TISSUE SERVICES

The undersigned has been given the opportunity to deny or withdraw the consent to procurement procedures without affecting my medical care. The undersigned hereby releases and forever discharges the obstetrician or certified nurse midwife, the hospital or birthing center, and their respective officers, directors, shareholders, employees, agents, consultants representatives, Affiliates, successors and assigns (collectively, the **"Released Parties"**) of and from any and all liability for any and all loss, harm, damage or claim of any kind arising from or relating to the collection of, or failure to collect, the Umbilical Cord Blood Specimen and/or Cord Tissue Specimen and the Birth Mother's Blood Specimen. The undersigned acknowledges that, by this release, the undersigned is giving up any right she may otherwise have, now or in the future, to sue or otherwise seek monetary damages or other relief against any of the Released Parties for any reason relating to the collection of, or failure to collect, the Umbilical Cord Blood Specimen and/or Cord Tissue Specimen and the Birth Mother's Blood Specimen. I have read the above information regarding infectious disease screening and HIV testing as well as the Authorization to Collect Umbilical Cord Blood and/Cord Tissue and Birth Mother's Blood; Release from Liability. I hereby consent to take the Infectious Disease and HIV testing and such future Infectious Disease and HIV testing as may be required by law, and I authorize the provider to collect Cord Blood and/or Cord Tissue and Birth Mother's Blood.

This Contract which contains- Enrollment Form; Cryo-Cell & Client Responsibilities; Health History - Informed Consent; Authorization to Collect Cord Blood and/or Cord Tissue and Birth Mother's Blood; Release from Liability; Consent of Non- Client Birth Carrier for Cord Blood and/or Cord Tissue Collection in the case of adoption/surrogacy; Services Purchased; and Payment Information is the entire Contract between the Parties with respect to the subject matter hereof, and supersedes all previous Contracts and understandings, whether written or oral, between the Parties.

Print Name: (First) (Last)	Print Name: (First) (Last)
Date	Date
Mother/Parent/Legal Guardian's Signature	Father/Co-Parent/Legal Guardian's Signature

Translator/Interpreter First and Last: Date

(If Applicable) (Family members shall not serve as interpreters or translators)

Regarding umbilical cord tissue, all private blood banks' activities for New York State residents are limited to collection, processing, and long-term storage does not indicate approval or endorsement of possible future uses or future suitability of these cells. Cryo-Cell's umbilical cord tissue service provides expectant families with the opportunity to cryogenically store their newborn's umbilical cord tissue cells contained within substantially intact cord tissue. Should umbilical cord tissue cells be considered for potential utilization in a future therapeutic application, further laboratory processing will be required.

CLIENT AGREEMENT AND INFORMED CONSENT FOR UMBILICAL CORD BLOOD AND CORD TISSUE SERVICES

SERVICES PURCHASED

Please check the appropriate box: ☐ New Client ☐ Returning Client

Please check the appropriate box for processing method you have chosen:

☐ Cryo-Cell Cord Blood HES Standard ☐ Cryo-Cell Cord Blood Prepacyte Premium

Please check the appropriate box for tissue storage: ☐ 2 Vials (Standard) ☐ 6 Vials (Max)

Please check the appropriate box for the Service(s) you have chosen.

☐ **Cryo-Cell's Umbilical Cord Blood and Cord Tissue Service – Annual Plan** **$**_____

The Annual Storage Plan includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and first year of storage fees. The first year Annual Storage Plan fee is due upon completion of processing. The Annual Storage Fee (_____) for year 2 and beyond is automatically charged to your credit/debit card during the month of the Child's birth. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Umbilical Cord Blood and Cord Tissue Service – 18-Year Plan** **$**_____

The 18 Year Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and 18 years of discounted, prepaid storage. The 18 year plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Umbilical Cord Blood and Cord Tissue Service – Lifetime Plan** **$**_____

The Lifetime Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and Lifetime prepaid storage for cord blood and cord tissue. The Lifetime plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Umbilical Cord Blood Service – Annual Plan** **$**_____

The Annual Storage Plan includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and first year of storage fees. The first year Annual Storage Plan fee is due upon completion of processing. The Annual Storage Fee (_____) for year 2 and beyond is automatically charged to your credit/debit card during the month of the Child's birth. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Umbilical Cord Blood Service – 18-Year Plan** **$**_____

The 18 Year Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and 18 years of discounted, prepaid storage. The 18 year plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Umbilical Cord Blood Service – Lifetime Plan** **$**_____

The Lifetime Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and Lifetime prepaid storage for cord blood. The Lifetime plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Cord Tissue Service – Annual Plan** **$**_____

The Annual Storage Plan includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and first year of storage fees. The first year Annual Storage Plan fee is due upon completion of processing. The Annual Storage Fee (_____) for year 2 and beyond is automatically charged to your credit/debit card during the month of the Child's birth. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Cord Tissue Service – 18-Year Plan** **$**_____

The 18 Year Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and 18 years of discounted, prepaid storage. The 18 year plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are more than 30 days past due.

☐ **Cryo-Cell's Cord Tissue Service – Lifetime Plan** **$**_____

The Lifetime Plan Fee includes processing, testing, medical courier (U.S. and Puerto Rico clients only) and Lifetime prepaid storage for cord tissue. The Lifetime plan is due upon completion of processing. There is a 1.5% interest charge per month for payments that are ore than 30 days past due.

Cryo-Cell's umbilical cord tissue service provides expectant families with the opportunity to cryogenically store their newborn's umbilical cord tissue cells contained within substantially intact cord tissue. Should umbilical cord tissue cells be considered for potential utilization in a future therapeutic application, further laboratory processing will be required.

PAYMENT INFORMATION

Credit/Debit Card: Must be completed for all payment options

a. Bill to credit/debit card: Upon processing of specimen(s) your credit/debit card provided will automatically be charged for the initial processing and annual storage fee. Annual storage fees will automatically be charged during baby's birth month.

b. If Client cancels Cryo-Cell's Service(s) prior to delivery, Client must notify Cryo-Cell and mail the collection kit back within 2 weeks of notification to avoid a $150 non-refundable cancellation fee. This fee will automatically be charged 30-45 days after the due date to the credit card provided.

c. If the Client's credit card information changes after the enrollment, it is the responsibility of the Client to update credit card information with Cryo-Cell for any future charges (annual storage fees, in house payment plans or cancellation fees).

□ Visa □ MasterCard □ American Express □ Discover □ Diners Club Name of

Cardholder:_____

Complete Billing Address:_____

Please call Cryo-Cell at 800-786-7235 option 1, if you need to change your credit card on file

Card Number:_____ Expiration Date:_____

Authorized Signature:_____

I have read and understand the Terms and Conditions of this Contract pertaining to Cryo-Cell Umbilical Cord Blood and Cord Tissue Service and desire to enroll in the Service selected in the Services Purchased page. I agree to the terms and conditions pertaining to the in-house payment plan if selected at enrollment. I must submit the completed Contract and all attachments to be eligible for the Cryo-Cell Payment Guarantee. The Cryo-Cell Payment Guarantee only applies if the cord blood unit is required for hematopoietic transplant and it fails to engraft, subject to the listed exclusions. The Cryo-Cell Payment Guarantee does not apply to the Cord Tissue Service. All of my questions regarding services and payment have been answered to my satisfaction. I certify that all the information I have provided to Cryo-Cell is true and correct to the best of my knowledge. I have signed this Contract freely and voluntarily.

Print Name: (First) (Last)	Print Name: (First) (Last)
Date	Date
Mother/Parent/Legal Guardian's Signature	Father/Co-Parent/Legal Guardian's Signature

Translator/Interpreter First and Last: Date

(If Applicable) (Family members shall not serve as interpreters or translators)

Cryo-Cell Payment Guarantee

Subject to the Terms and Conditions below, if the child's cryopreserved cord blood was processed with our Premium PrepaCyte-CB processing method and fails to engraft in a stem cell transplant, Cryo-Cell will pay the Client $100,000; if the processing method was our standard HES processing method and fails to engraft, Cryo-Cell will pay the Client $75,000.

Terms and Conditions:

Subject to the requirements set forth below, if a Client's cord blood is processed and stored by Cryo-Cell and is used for hematopoietic stem cell transplant using recognized medical practices and fails to engraft, Cryo-Cell will pay the Client $100,000 or $75,000, depending on processing method. Engraftment is defined as three Consecutive days in which the transplant recipient's absolute neutrophil count (ANC) is equal to or greater than 500/microliter with the first measurement occurring within 100 days of transplantation. The engrafted cells must be of donor origin.

Cryo-Cell Payment Guarantee requirements:

- The cord blood must be collected using Cryo-Cell's collection kit or approved alternative collection technique.
- The cord blood must be processed and at all times cryopreserved by Cryo-Cell.
- **$100,000 Payment Guarantee** applies only to specimens processed under the premium processing method PrepaCyte-CB.
- **$75,000 Payment Guarantee** applies only to specimens processed under the standard processing method HES.
- The cryopreserved cord blood must be used in a stem cell transplant for homologous use (hematopoietic reconstitution) by the donor or by a first-degree blood relative (the "Immediate Family"). The cryopreserved cord blood must be administered under the direction of a transplant physician in a medical facility qualified by an Institutional Review Board (IRB) for stem cell transplantation.
- The cryopreserved cord blood must not be subject to more than minimal manipulation before administration including, but not limited to:
    - Gene therapy
    - Cell selection techniques
    - Ex-vivo cell expansion
- The cryopreserved cord blood must not be used in a transplant subject to US Food and Drug Administration (FDA) investigational new drug (IND) application or foreign equivalent.
- The cryopreserved cord blood must not be used in experimental procedures, including mini-transplants. The transplant recipient must not have used an investigational drug within 100 days of transplantation.
- The cryopreserved cord blood must contain at least 2×10^7 total nucleated cells (TNC) per kilogram weight of recipient.
- The cryopreserved cord blood must contain at least 1×10^5 CD34+ cells per kilogram weight of recipient.
- Specimen cannot be deemed Suboptimal by Cryo-Cell
- The cryopreserved cord blood must not be combined with supplemental stem cell sources for transplantation, such as additional cord blood, peripheral blood or bone marrow.
- HLA tissue typing: donor cells must be at least a 4 out of 6 match to the recipient.
- The cord blood thawing procedure must be a validated procedure used by the transplant facility and the cord blood must be administered immediately upon thawing.

Documentation Requirements:

- Signed statement from the transplant physician attesting that engraftment did not occur along with supporting medical records documenting proof of non-engraftment.

Cryo-Cell Payment Guarantee is not available to:

- Clients whose cord blood banking fees are paid by Medicare or Medicaid.
- Clients enrolled in Cryo-Cell's Designated Transplant Program.

Notification of Insurance

By accepting payment via the Cryo-Cell Payment Guarantee, the recipient agrees to notify any third-party payer who paid in part or wholly for the collection, storage, or transplant, of the existence of this Cryo-Cell Payment Guarantee, the amount paid and all other terms and conditions. Prior to payment of the Cryo-Cell Payment Guarantee, Cryo-Cell must have proof, in writing, that all third-party payers involved in paying for collection, storage or transplant have been notified.

ADDITIONAL INFORMATION

- This Cryo-Cell Payment Guarantee is valid for Clients who have signed Cryo-Cell's standard contract and Agreement covering cord blood services and whose payments to Cryo-Cell for services are current. Client should note that banking a newborn's cord blood does not guarantee that the umbilical cord blood will be a match for a family member, that a cord blood stem cell transplant would be the first or best course of treatment for any particular disease or that a child's own cord blood is useful for every disease treatable by stem cell transplantation. A medical care provider ultimately decides whether the use of your Child's cord blood sample is indicated, based on the nature and progression of the disease and the HLA matching for donor and recipient. This offer is independent from and in no way diminishes the effect of Cryo-Cell's limitation of liability set forth in its Agreement with client.
- This Cryo-Cell Payment Guarantee is available only to Clients enrolling under the new service Agreement and associated fee structure beginning on or about June, 15 2017. The Cryo-Cell Payment Guarantee is not retroactive to enrollments occurring before June, 15 2017.
- Any applicable federal, state or local taxes associated with the payments defined herein are the sole responsibility of the Client.

HEALTH HISTORY- EDUCATIONAL MATERIAL

Please notify Customer Service if you are using a Surrogate or this is an Adoption to request a Birth Carrier Enrollment Packet.
If you have used a donor sperm, egg or embryo please call customer service to request additional FDA Donation Eligibility form.

EDUCATIONAL MATERIALS	**Making Your Collection Safe!**
PLEASE READ THIS INFORMATION BEFORE YOU COMPLETE THE HEALTH HISTORY QUESTIONNAIRE	
If you have any questions any time during the screening process contact Cryo-Cell International at **800-786-7235 option 1**	

ACCURACY AND HONESTY ARE ESSENTIAL!	Your **complete honesty** in answering all questions is very important.
ALL INFORMATION YOU PROVIDE IS CONFIDENTIAL	

DONOR ELIGIBILITY-SPECIFIC INFORMATION	
WHY WE ASK QUESTIONS ABOUT SEXUAL CONTACT	Sexual contact may cause contagious diseases like HIV to get into the bloodstream and be spread through transfusions or transplants to someone else.
DEFINITION OF "SEXUAL CONTACT"	The words "have sexual contact with" and "sex" is used in some of the questions we will ask you, and apply to any of the activities below, whether or not a condom or other protection was used: 1. Vaginal sex (contact between penis and vagina) 2. Oral sex (mouth or tongue on someone's vagina, penis, or anus) 3. Anal sex (contact between penis and anus)
HIV/AIDS RISK BEHAVIORS AND SYMPTOMS	AIDS is caused by HIV, for which there is no cure. When a person becomes infected with HIV, the virus enters the blood stream and destroys certain cells of the immune system, resulting in the inability to fight off various infections. These infections, not the HIV itself, may cause death. HIV is spread mainly through sexual contact with an infected person OR by sharing needles or syringes used for injecting drugs or steroids. Behaviors that increase your risk of being infected with HIV include: having unprotected sex with someone who has been infected with HIV; sharing needles, getting a tattoo, blood transfusions or organ transplants..

INFORM CRYO-CELL IF YOU:

- **Have AIDS or have ever had a positive HIV test**
- Have used needles to take drugs, steroids, or anything not prescribed by your doctor in the past 5 years
- Are a male who has had sexual contact with another male, even once, in the past 5 years
- Have taken money, drugs or other payment for sex in the past 5 years
- Have had sexual contact in the past 12 months with anyone described above
- Have had syphilis or gonorrhea in the past 12 months
- In the last 12 months have been in juvenile detention, lockup, jail or prison for more than 72 hours
- Have any of the following conditions that can be signs or symptoms of HIV/AIDS:
  - Unexplained weight loss or night sweats
  - Blue or purple spots in your mouth or skin
  - Swollen lymph nodes for more than one month
  - White spots or unusual sores in your mouth
  - Cough that won't go away or shortness of breath
  - Diarrhea that won't go away
  - Fever of more than 100.5° F for more than 10 days

Remember that you CAN give HIV to someone else even if you feel well and have a negative HIV test. This is because tests cannot detect infections for a period of time after a person is exposed to HIV. **If you think you may be at risk for HIV/AIDS please inform Cryo-Cell International.**

MEDICATION DEFERRAL LIST		**Please Check:** ☐ **I HAVE NOT taken any of these Medications.** ☐ **I HAVE taken/currently taking a medication listed. Please list on Question 3.**
Medication	**Usual Reason Taken**	**IF YOU WOULD LIKE TO KNOW WHY THESE MEDICINES AFFECT YOU AS A DONOR:**
Growth hormone from human pituitary glands	Used usually for children with delayed or impaired growth.	The hormone was obtained from human pituitary glands, which are found in the brain. Some people who took this hormone developed a rare nervous system condition called Creutzfeldt - Jakob disease (CJD, for short). Potential donors who have taken growth hormone from human pituitary glands should be evaluated by the Medical Director.
Insulin from cows (bovine, or beef, insulin) **NOTE: This does NOT include insulin made synthetically** such as Lispro, Aspart, Apidra, Levemir. If unsure ask your physician or call Cryo-Cell.	Used to treat diabetes.	An injected material used to treat diabetes. If this insulin was imported into the US from countries in which "Mad Cow Disease" has been found, it could contain material from infected cattle. There is concern that "Mad Cow Disease" is transmitted by transfusions and transplants. Potential donors who have taken insulin from cows should be evaluated by the Medical Director.
Hepatitis B Immune Globulin (HBIG) **NOTE:** This is different from the hepatitis B vaccine, which is a series of 3 injections given over a 6 month period to prevent future infection from exposures to hep B.	Given following an exposure to hepatitis B.	HBIG does not prevent hepatitis B infection in every case, therefore potential donors who have taken hepatitis B Immune Globulin should be evaluated by the Medical Director to be sure they were not infected. Hepatitis B can be transmitted, through transfusions and transplants, to a patient.
Unlicensed vaccine	Usually associated with a research protocol	The effect with regard to stem cell recipients is unknown. Potential donors who have taken unlicensed vaccines should be evaluated by the Medical Director.
TRAVEL TO, OR BIRTH IN, OTHER COUNTRIES		Donor screening tests may not be available for some contagious diseases that are found only in certain countries. If you were born in, have lived in, or visited certain countries, please inform the staff.

INFORMED CONSENT

BACKGROUND

Before birth, a baby's blood cells move through his/her body, umbilical cord, and placenta. These blood cells carry oxygen and nutrition from the mother's blood to the baby. After the birth of a baby, the umbilical cord is clamped and cut, separating the baby from the placenta, which is delivered several minutes later and is usually discarded. The umbilical cord is then cleansed and a needle is inserted into the umbilical vein for collection of the cord blood. The placenta contains one-third (1/3) to one-half (1/2) of a cup of umbilical cord blood. This blood is rich in blood stem cells, which is being studied for its usefulness in replacing the blood-forming cells in persons with certain diseases. The umbilical cord contains a different type of stem cell, called mesenchymal stem cells. Cryo-Cell provides the service of collecting, transporting, testing, processing, and cryogenic storage of both umbilical cord blood and umbilical cord tissue.

INITIAL STEPS

Because you have enrolled in our service, you are being provided with this Educational Material, Health History Questionnaire, and Client Agreement. Cryo-Cell is required to take health history information and answer any questions you have related to our service. To complete the Health History Questionnaire, you will be asked questions related to your medical history, genetic history, sexual and social history. You may find some of these questions to be very personal. You will also be asked to provide health history information about the biological father and his family. You may choose to not answer questions, but this may limit the availability of your stem cells. The Client Agreement form includes the agreement between you and Cryo-Cell for collection, transport, testing, processing, and cryogenic storage. It also contains the informed consent that is required to be signed. If anything is incomplete, we will follow up with you to ensure all required paperwork is complete.

AT THE HOSPITAL

The cord blood is collected after delivery of your baby either while the placenta is still in your body or after it has been delivered. Included in your kit are the instructions that your Health Care Provider uses to collect the cord blood. There is no change in the actual delivery process.

Your doctor can cancel the cord blood collection at any time if he/she thinks it might pose a potential harm to you or your baby.

Maternal Blood (about 20 ml) will be taken from your arm for infectious disease marker tests. This may cause pain, bruising, infection or fainting. If the infectious disease testing performed on your blood is positive, you will be informed by your physician or the cord blood bank personnel of these test results. This may cause you to have to deal with health concerns that may or may not happen in the future. In addition, if required by federal, state or local law, some positive results will be reported directly to your state health department.

The cord blood bank staff will review the hospital medical charts of you and your baby. They will look for prenatal test results including HIV (the virus that causes AIDS), syphilis, and hepatitis tests and other medical information that pertain to your baby's cord blood unit. They are also required to complete the Health Care Provider form that was included in your kit. It is important that this form is complete and they have signed.

You will receive a Client Information form in your kit. The purpose of this form is to update any changes to your health status between the time you filled out your Health History Questionnaire and the time you deliver. Keep it with the kit so that you can fill out the form at that time and send it back with the cord blood. We are required to have your documented health status within 48 hours of delivery.

This Client Information form also includes the option to upgrade. If you choose to upgrade the Cryo-Cell representative that assists you with the pickup of your kit will review the pricing changes with you. You may also choose to stay with what you originally signed up for. Once Cryo-Cell processes your specimen, it is not possible to upgrade. The current processes that Cryo-Cell offer:

- Premium cord blood process: Uses newer technology that depletes up to 99% of red blood cells.
- Standard Cord Blood Process: Uses industry standard technology.
- Cord Tissue: Cord tissue is stored in either 2 vials or 6 vials. Additional vials allow for more uses.

Once your kit has been sent to Cryo-Cell, the sample is verified against the Client Information form and Health Care Provider form. We will follow up with you if anything is incomplete.

Cryo-Cell will then have the maternal tubes tested and process according to the agreement. If you have indicated on the Client Agreement form that you have upgraded, the Laboratory will confirm with the Cryo-Cell Representative that processed the pickup to confirm to proceed with the upgrade. The lab will process, cryopreserve, and then cryogenically store your products in an assigned location. The lab performs Quality Control tests. If your product does not meet our specifications, you will be contacted to discuss your options. You will receive a certificate with the processing information.

FOR CONSENT:

I understand that my physician, physician's designee, or midwife will perform the collection of the cord blood after the delivery of my baby, while the delivery of the placenta occurs. He/she will use methods provided by Cryo-Cell International, Inc. in their standard operational procedures. Medical conditions may arise which preclude the collection of the cord blood and will be decided at the sole discretion of the attending physician.

☞ **I HAVE READ THE ABOVE EDUCATIONAL MATERIALS** AND INFORMED CONSENT

(PLEASE CHECK): ☐ YES ☐ NO

If you (the client) would like further information regarding the donor eligibility and the questions please refer to the U.S. Food and Drug Administration Guidance for Industry: Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps).

Health History Questionnaire

Countries in the United Kingdom: ***Refer to questions 25 and 27, pg. 6***

COUNTRY	TIME SPENT IN COUNTRY **from 1980 to 1996**:			
	Time Spent:	Circle one that applies:	Dates: From:	To:
England		DAYS / MONTHS / YEARS		
Northern Ireland		DAYS / MONTHS / YEARS		
Scotland		DAYS / MONTHS / YEARS		
Wales		DAYS / MONTHS / YEARS		
Isle of Man		DAYS / MONTHS / YEARS		
Channel Islands		DAYS / MONTHS / YEARS		
Gibraltar		DAYS / MONTHS / YEARS		
Falkland Islands		DAYS / MONTHS / YEARS		

Countries in Europe: ***Refer to question 27, pg. 6***
IF total travel to these areas is 5 years or greater, FROM 1980 to PRESENT – list travel and dates below.
Examples to document travel that is:

Less than 4 weeks note **< 1 MONTH** in Departed box.
OR More than 4 weeks note by months: Arrived: August 2014; Departed November 2014 (*mm/yyyy*)
OR If Resident, check X next to country (**Note how long you have been a resident**)

X if Resident	COUNTRY	DATES OF TRAVEL Arrived	Departed	X if Resident	COUNTRY	DATES OF TRAVEL Arrived	Departed
	Albania				Luxembourg		
	Austria				Netherlands		
	Belgium				Norway		
	Bulgaria				Poland		
	Canary Island				Portugal		
	Czech Republic				Romania		
	Denmark / Greenland				Saudi Arabia		
	Finland				Slovak Republic		
	France / Corsica				Spain		
	Germany				Sweden		
	Greece / Crete				Switzerland		
	Hungary				Turkey		
	Ireland				United Kingdom (see list, Question 25)		
	Italy				Yugoslavia (now **Slovenia, Macedonia, Croatia, Serbia, Montenegro, Kosovo and Bosnia/Herzegovina**)		
	Liechtenstein						

If visited a country more than once, use the section below to note what country and all additional dates.

Multiple visits to:	**Dates visited:**

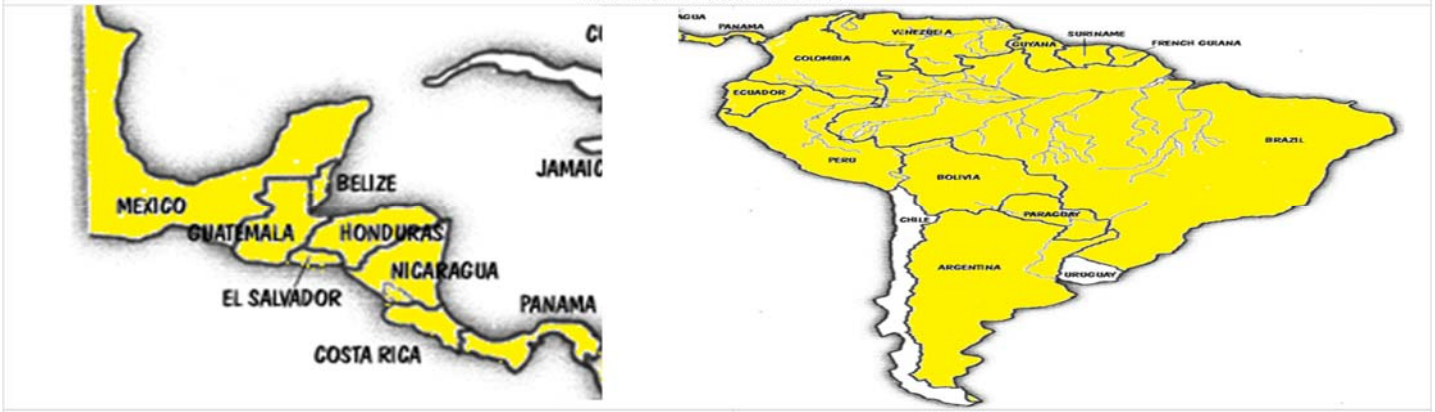
☐ **I lived in a European country that is not listed**

Health History Questionnaire

Travel Maps: *Refer to question 22*

CARIBBEAN - **Including Puerto Rico**

CENTRAL AND SOUTH AMERICA



ASIA - **INCLUDING PACIFIC ISLANDS:**

AFRICA

☞ ☐ **CHECK IF NO TRAVEL TO THESE AREAS IN THE PAST 3 YEARS**

Using the maps as reference, include any countries traveled to **in the past 3 years.** Include all cities and the dates of travel (arrived / departed). This includes residence/and travel to Puerto Rico, Mexico and the Caribbean.				
If Resident, check X next to country (**Resident =** lived there for 3 years or more)				
X if Resident	Country	Cities	Dates of Travel (**MONTH / YEAR at minimum**): Arrived	Departed

Health History Questionnaire

Please use a pen and circle your answers and provide any explanations needing clarification. If you need assistance completing this questionnaire please call 800-786-7235 option 1.
Questionnaire must be completed to its entirety.

1.	Are you currently taking **an antibiotic**?	**If yes**: name/Reason:	**YES NO**
2.	Are you currently taking any other medication **for an infection?**	**If yes**: name/Reason:	**YES NO**
3.	Are you now taking or have you ever taken any medications **on the Medication List attached (page 1)**? **If Yes:**		**YES NO**

Name of Medication	Date Started	Date Ended (or Current)

4.	Have you read the Educational Materials attached (**pages 1-2),** If no, **please read prior to continuing**		**YES NO**
5.	In the past **8 weeks** have you received a **FLU, TDAP and/or RhoGAM** shot?		**YES NO**
	In the past **8 weeks** have you had **any other** vaccinations or shots? If Yes:		**YES NO**

Name:	Date of shot	Reason	Route (circle)
			Injected / Nasal / Oral

6.	Have you had contact with anyone who had a **smallpox** vaccination in the past **12 weeks**?	**YES NO**
7.	In the past **12 months** have you been told by a healthcare professional that you have West Nile Virus infection or any positive test for West Nile Virus?	**YES NO**
8.	In the past **12 months** have you had a blood transfusion? If **yes**, date(s)? _____	**YES NO**
9.	In the past **12 months** have you come into contact with anyone else's blood? If **yes,** check if person is known / suspected of having: ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C ☐ Not Known ☐ Does NOT have	**YES NO**
10.	In the past **12 months** have you had an accidental needle stick? If **yes**, were you exposed to someone else's blood through the needle-stick? ☐ **YES** ☐**NO** If **yes,** check if person is known / suspected of having: ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C ☐ Not Known ☐ Does NOT have	**YES NO**
11.	In the past **12 months** have you had a transplant or graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, sclera, bone, skin or other tissue?	**YES NO**
12.	In the past **12 months** have you had sexual contact with anyone who has HIV/AIDS or has had a positive test for HIV/AIDS virus? If **yes**, when? _____	**YES NO**
13.	In the past **12 months** have you had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex? If **yes**, was the activity within the last 5 years? ☐ **YES** ☐ **NO**	**YES NO**
14.	In the past **12 months** had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything **not prescribed** by their doctor? If **yes**, was the use within the last 5 years? ☐ **YES** ☐ **NO**	**YES NO**
15.	In the past **12 months** had sexual contact with a male who has ever had sexual contact with another male? If **yes**, was the activity **within the last 5 years**? ☐ **YES** ☐ **NO**	**YES NO**
16.	In the past **12 months** had sexual contact with a person who has hepatitis? If **yes, check if**: ☐ Hepatitis B ☐ Symptomatic Hepatitis C **OR** ☐ Asymptomatic Hepatitis C ☐ NON-Viral OR ☐ UNKNOWN what type of hepatitis	**YES NO**
17.	In the past **12 months** lived with a person who has hepatitis? If **yes, check if:** ☐ Hepatitis B ☐ Symptomatic Hepatitis C **OR** ☐ Asymptomatic Hepatitis C ☐ NON-Viral OR ☐ UNKNOWN what type of hepatitis	**YES NO**
18.	In the past **12 months** had a tattoo (including cosmetic tattoo)? If yes, Date: _____ What US state was it applied in? _____ Was it Performed using sterilized, single use equipment? ☐ **YES** ☐**NO**	**YES NO**
19.	In the past **12 months** had an ear or body piercing? If yes, Date: _____ What US state was it applied in? _____ Was it Performed using sterilized, single use equipment? ☐ **YES** ☐ **NO**	**YES NO**

Health History Questionnaire

20.	In the past **12 months** have you had or been treated for syphilis or other sexually transmitted infections? If **yes, check if**: ☐ Preventative Treatment ☐ Active (current outbreak or being treated for) HPV, genital herpes, or gonorrhea ☐ Syphilis	**YES NO**
21.	In the past **12 months** have you been in juvenile, lockup, jail, or prison for more than 72 consecutive hours?	**YES NO**
22.	In the past **3 years** have you been outside the United States or Canada? If **YES**, **please complete page 4**	**YES NO**
23.	In the past **5 years** have you received money, drugs or other payment for sex?	**YES NO**
24.	In the past **5 years** have you used needles to take drugs, steroids, or anything **not prescribed** by your doctor?	**YES NO**
25.	From **1980 through 1996** Did you spend time that **adds up to three (3) months or more** in the United Kingdom? If **yes**, please complete **page 3** to add the time spent to all that apply	**YES NO**
26.	From **1980 through 1996** Were you a member of the U.S. Military, a civilian military employee, or a dependent of either a member of the U.S. military or civilian military employee? **IF YES:** Did you spend a total time of **6 months or more** associated with a military base in any of the following countries? ☐ From 1980 through 1990 in Belgium, the Netherlands or Germany? ☐ From 1980 through 1996 in Spain, Portugal, Turkey, Italy or Greece? ☐ Did NOT spend total time of 6 months or more in the listed military bases	**YES NO**
27.	From **1980 to the present**, did you spend time that **adds up to five (5) YEARS or more** in Europe? If **yes**, please complete **page 3** to add the time spent to all that apply	**YES NO**
28.	From **1980 to the present**, did you receive a transfusion of blood or blood components in the United Kingdom?	**YES NO**
29.	Have you **EVER** had any positive test for the HIV/AIDS virus? If **yes, contact Cryo-Cell (800)-786-7235 option 1**	**YES NO**
30.	Have you **EVER** had hepatitis or any positive test for hepatitis? If **yes**, check if: ☐ BEFORE your 11th birthday ☐ Non-viral hepatitis (not caused by Hepatitis B or Hepatitis C)	**YES NO**
31.	Have you **EVER** had malaria? If **yes**, have you been asymptomatic for more than 3 years? ☐ **YES** ☐**NO**	**YES NO**
32.	Have you **EVER** had Chagas' disease and/or a positive test for *T. cruzi*? If **yes**, when? _____	**YES NO**
33.	Have you **EVER** had babesiosis? If **yes**, when? _____	**YES NO**
34.	Have you **EVER** Received a dura mater (or brain covering) graft? If **yes,** was it: ☐ Human Derived ☐Non-Human source ☐Unknown	**YES NO**
35.	Have you **EVER** been diagnosed with any neurological disease? If **yes**, check if diagnosis for ☐ vCJD / CJD (Creutzfeldt - Jakob disease) ☐ Dementia, degenerative or demyelinating of the central nervous system ☐ Unknown origin	**YES NO**
36.	Have you **EVER** had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal? If **yes**, what? _____	**YES NO**
37.	Have you **EVER** tested positive for HTLV, had adult T-cell leukemia, or had unexplained paraparesis (partial paralysis affecting the lower limbs?) If **yes**, which one and when? _____	**YES NO**
38.	Has your sexual partner or a member of your household ever had a transplant or other medical procedure that involved being exposed to live cells, tissues or organs from an animal?	**YES NO**
39.	Have any of your relatives, the baby's father or any of the baby's other relatives had Creutzfeldt-Jakob disease? If **yes**, check if they are: ☐ **Blood Relative** If related by blood, is the disease a result of a surgical procedure or injection of growth hormone? ☐ **YES** ☐**NO** ☐**Unknown** ☐ **Related through marriage**	**YES NO**

Health History Questionnaire

40.	Have you had cancer, a genetic or inherited disorder or autoimmune disease? If **yes**, please provide: Type of Cancer / Disorder/Disease | When Diagnosed (month/year) | Currently cancer / disease free?	**YES NO**
41.	Have father, siblings, grandparents, or parent's siblings (baby's aunt or uncle) had cancer, a genetic or inherited disorder or autoimmune disease? Relationship to the baby | Mother's or Father's side? | Type of Cancer / Disorder / Disease | When Diagnosed (month/year) | Currently cancer / disease free?	**YES NO**
42.	At any point during the pregnancy have you had a medical diagnosis of a Zika virus infection?	**YES NO**
43.	At any point during the pregnancy have you lived in or traveled to an area with active Zika virus transmission? (Review the most current list of ZIKA virus areas of transmission http://www.cdc.gov/zika/geo/index.html) or Call Cryo-Cell International for guidance 800-786-7235 option 1.	**YES NO**
44.	At any point during the pregnancy have you had sexual contact with a person who, in the 6 months prior to sexual contact, has had a Zika virus infection or lived in or traveled to an area with active Zika virus transmission?	**YES NO**
45	In the last 28 days have you: Cared for, lived with, or otherwise had close contact with individuals diagnosed with or suspected of having COVID-19 infection	**YES NO**
	-or- Been diagnosed with or suspected of having COVID-19 infection	**YES NO**

☞ I have completed the Health History Questionnaire honestly and to the best of my knowledge.

SIGNATURE

I agree to collection, processing, testing, and storage of my specimens.

_____
Printed First and Last Name

_____ _____
Birth Mother's Signature Date

_____ _____
Translator/Interpreter - Print First and Last Name (if applicable) Date
(Family members shall not serve as interpreters or translators)

If you (the client) would like further information regarding the donor eligibility and the questions please refer to the U.S. Food and Drug Administration Guidance for Industry: Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps).

☐ Review Complete

CRYO-CELL USE ONLY

Reviewed by: _____ Date: _____ Medical Director Review: _____ Date: _____
(Initials) (if applicable)