STATEMENT OF PHYSICIAN RESPONSIBILITY

Dear Doctor:

Please use this form when you wish to be billed directly by the California Cryobank, Inc. for services rendered to your practice. Your signature on this agreement indicates your acceptance of the terms.

I agree to inform all patients using specimens provided by the California Cryobank, Inc. of the risks and limitations of artificial insemination. I further agree to require each patient to certify that they will never attempt to identify or locate any donor of the California Cryobank, Inc.. I agree to keep the Cryobank informed of all pregnancies or adverse reactions resulting from the use of sperm obtained from the Cryobank.

In addition, I agree to accept full financial responsibility for all charges incurred by my office in connection with services provided by the California Cryobank, Inc. I understand that this responsibility includes my payment upon receipt of invoice for all orders placed by my staff or other physicians in my office. I further understand that unused specimens cannot be returned for credit.

Doctor's Signature ______________________

License Number ______________________

Mailing Address ______________________

Billing Information

Full Name of Responsible Party/Parties ______________________

Full Name of Facility, Clinic or Medical Corporation ______________________

Billing address (if different from above) ______________________

Name of Billing Contact Person ______________________

Telephone ______________________

FAX Telephone ______________________

Purchase Order # (if applicable) ______________________

CCB-1000, 8/93

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FOR CCB USE ONLY

Date Received ______________________

Account Number ______________________

Order Number ______________________

By ______________________ Date __/__/__

______________________ Date __/__/__

______________________ Date __/__/__

______________________ Date __/__/__