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Centre of Reproductive Medicine and Andrology

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World Health Organization

WHO Collaborating
Centre for Research in
Male Reproduction



Training Centre
European Academy of
Andrology

Declaration of consent for the termination of cryopreservation

Ms _____, born _____

Mr _____, born _____

resident _____

I/we would like the following cryopreserved material to be destroyed:

(Please tick accordingly and insert number if applicable, for male samples male signature only required, for female samples female signature only required, for fertilised oocytes or embryos signature of BOTH partners required.)

- | | | | |
|---|---------|---|---------|
| <input type="checkbox"/> cryo sperm | (_____) | <input type="checkbox"/> unfertilised oocytes | (_____) |
| <input type="checkbox"/> TESE samples | (_____) | <input type="checkbox"/> fertilised oocytes | (_____) |
| <input type="checkbox"/> MESA samples | (_____) | <input type="checkbox"/> embryos | (_____) |
| <input type="checkbox"/> other samples: | _____ | | |

Place _____, date _____

Signature female patient _____

Signature male patient _____