

## Canada – Pregnancy Pledge Verification Form

The completion of this form serves as verification of insemination and/or IVF procedures in 4 treatment cycles and negative pregnancy outcome for the purpose of receiving one free vial of donor semen per the **Free Vial Offer: Pregnancy Pledge program**.

**Form must be completed and signed by a physician to qualify.**

### Physician Information:

Physician Name – first name, last name		
Medical License Number (obtain from your physician's office)		
Clinic Name		
Address		
City	Province	Postal Code
Contact Person		Contact Email Address
Phone Number		Fax Number
Physician Email Address		

### Procedure Information:

<i>Date of Procedure</i>	<i>Donor Number</i>

**Client Information:** Client is the person who had the ART procedures performed

Client Name – first name, last name		
Address		
City	Province	Postal Code
Phone Number		Email Address
Date Of Birth  (client must be 38 or less at the time of the first procedure date above)		

Signature of Physician below indicates verification of the above entered information.

I certify that the client listed above has had at least 4 cycles with in-office ART procedures (IUI, ICI, or IVF) using donor semen from Fairfax Cryobank, Inc. distributors and has not had a positive clinical pregnancy as defined by a fetal heartbeat detected by ultrasound. The clients date of birth and procedure information listed above is accurate.

Physician Signature

Date

**Please mail or Fax the completed form to the distributor where you purchased the samples.**

CAN-AM Cryoservices  
1605 Main St W, Unit 3  
Hamilton, ON, L8S 1E6  
Canada Fax:905-524-3969

ReproMed Ltd.  
56 Aberfoyle Crescent  
Toronto, Ontario M8X 2W4  
Canada Fax: 416-233-9180

Cryobank Use Only:

☐ Order information verified by \_\_\_\_\_ / \_\_\_\_\_.  
Initials date

☐ Client contacted to notify of Free vial Offer: Pregnancy Pledge vial credit authorization. \_\_\_\_\_ / \_\_\_\_\_.  
Initials date