Vial Transfer and Storage

Donor ID: _______________ Vial ID: _______________ Vial Date: _______________

Bank/Clinic Name: ____

Bank/Clinic Address: ____

Bank/Clinic City: ____________________________________ Bank/Clinic State: _________ Zip: ________

Bank/Clinic Phone: ______________________________ Email: ______________________________________

Bank/Clinic Contact Name: ____

Client/Account Name: ____

A new form must be made for each vial being transferred and stored. Before Cryobank America can accept a vial transfer from another facility for storage, we require a copy of the original donor eligibility documents (Initial IDT; Initial Physical Exam; Initial Donor/Family Medical and Social History; and 6-month IDT).
The following must also be completed:

Requirement	**Date Completed**	**Acceptable/Unacceptable**
Donor Personal and Family Health History	_______________	_______________
Donor Physical Examination	_______________	_______________
Initial IDT Testing	**Date Completed**	**Negative/Positive**
Chlamydia trachomatis (*C. trachomatis*)	_______________	_______________
Cystic Fibrosis (Not required)	_______________	_______________
Cytomegalovirus Antibodies (Total Antibody)	_______________	_______________
Cytomegalovirus Antibodies (IgM fraction)	_______________	_______________
HBV	_______________	_______________
Hepatitis B Surface Antigen (HBsAg)	_______________	_______________
Hepatitis B Core Antibody (HBcAb; HBc IgG-IgM)	_______________	_______________
Hepatitis C Virus Antibody (HCV)	_______________	_______________
HIV-1 / HCV / H / HBV NAT	_______________	_______________
Human Immunodeficiency Virus 1, O, and 2 (HIV 1/O/2)	_______________	_______________
Human T-Cell Lymphotropic Virus-I / II (HTLV-I / II)	_______________	_______________
Neisseria gonorrhea (*N. gonorrhea*)	_______________	_______________
Syphilis serology (*Treponema pallidum*)	_______________	_______________

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6-Month IDT Testing

Chlamydia trachomatis (*C. trachomatis*)	______________	______________
Cytomegalovirus Antibodies (Total Antibody)	______________	______________
Cytomegalovirus Antibodies (IgM fraction)	______________	______________
Hepatitis B Surface Antigen	______________	______________
Hepatitis B Core Antibody	______________	______________
Hepatitis C Virus Antibody (HCV)	______________	______________
HIV-1 / HCV / H / HBV NAT	______________	______________
Human Immunodeficiency Virus 1, O, and 2 (HIV 1/O/2)	______________	______________
Human T-Cell Lymphotropic Virus-I / II (HTLV-I / II)	______________	______________
Neisseria gonorrhea (*N. gonorrhea*)	______________	______________
Syphilis serology (*Treponema pallidum*)	______________	______________

I ____ (Physician/Designee) affirm that the completed donor eligibility screening as described above, has been tested and completed using FDA regulations and requirements. The semen specimen from donor ID _____________, dated on _____________, is permissible for transfer to Cryobank America LLC laboratories and is suitable for donor insemination purposes.

Physician/Designee Name Signature: ____ Date Signed: _______________

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Document must be mailed, faxed, or scanned and emailed to:

Cryobank America, LLC
Attn: Vial Transfer Request
3050 S. Center St.
Suite 100
Arlington, TX 76014-2153

Fax: (817) 549 - 5179

Email: forms@cryobankamerica.com

Please keep a copy for your records!

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FOR CRYOBANK AMERICA, LLC USE ONLY:

- ☐ Initial IDT
- ☐ Physical
- ☐ Medical History
- ☐ 6-Month IDT
- ☐ Accept Transfer
- ☐ Deny Transfer

DATE RECEIVED: _____________ NAME: __________________________ SIGNATURE: _________________________

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