Exception Request – Reproductive Tissue

TISSUE BANK REQUESTING EXCEPTION

Facility Name _____ NYS Facility ID # _____

Street Address _____

City _____ State _____ ZIP Code _____

Telephone _____ Fax _____

Contact Name _____ Contact E-mail Address _____

EXCEPTION FOR

☐ Import of donor tissue from an unlicensed tissue bank

☐ Creation of embryos for donation

☐ Use of tissue from a donor who tested positive for an infectious agent

TISSUE TYPE

☐ Semen # Vials _____

☐ Oocyte(s) # _____

☐ Embryo(s) # _____

☐ Other _____

INTENDED PROCEDURE

☐ Insemination

☐ Implantation

☐ Creation of Embryo(s) for Donation

☐ Other _____

TISSUE BANK WHERE TISSUE IS CURRENTLY STORED (If different than above)

Facility Name _____ NYS Facility ID # (if applicable) _____

Street Address _____ City _____

State _____ ZIP Code _____ Telephone _____

TISSUE BANK WHERE TISSUE WAS COLLECTED (If different than above)

Facility Name _____ NYS Facility ID # (if applicable) _____

Street Address _____ City _____

State _____ ZIP Code _____ Telephone _____

Exception Request – Reproductive Tissue

RECIPIENT IDENTIFIER (Not all fields are required)

Medical Record Number # _____ DOB _____

Initials _____ Other _____

Is the recipient a gestational carrier? ◯ Yes ◯ No

SEMEN TISSUE SOURCE

Identifier: _____ ◯ Anonymous donor ◯ Directed donor ◯ Client-depositor

◯ Was screened and tested as required by Part 52 prior to tissue collection and has no significant findings.

◯ Was screened and tested as required by Part 52 after tissue collection and has no significant findings.

◯ Was screened and tested as required by Part 52 and has the following significant or disqualifying findings:

OOCYTE TISSUE SOURCE

Identifier: _____ ◯ Anonymous donor ◯ Directed donor ◯ Client-depositor

◯ Was screened and tested as required by Part 52 prior to tissue collection and has no significant findings.

◯ Was screened and tested as required by Part 52 after tissue collection and has no significant findings.

◯ Was screened and tested as required by Part 52 and has the following significant or disqualifying findings:

EMBRYO TISSUE SOURCES (Indicate all applicable)

Semen source identifier: _____ ◯ Anonymous donor ◯ Directed donor ◯ Client-depositor

◯ Was screened and tested as required by Part 52 prior to tissue collection and has no significant findings.
◯ Was screened and tested as required by Part 52 after tissue collection and has no significant findings.
◯ Was screened and tested as required by Part 52 and has the following significant or disqualifying findings:

Oocyte source identifier: _____ ◯ Anonymous donor ◯ Directed donor ◯ Client-depositor

◯ Was screened and tested as required by Part 52 prior to tissue collection and has no significant findings.
◯ Was screened and tested as required by Part 52 after tissue collection and has no significant findings.
◯ Was screened and tested as required by Part 52 and has the following significant or disqualifying findings:

By signing below, I indicate I have approved the use of tissue from this donor(s).

Medical Director Name _____ Medical Director Signature _____ Date _____

Submit this form and any supporting documentation to New York State Department of Health Tissue Resources Program at: tissue@health.ny.gov.