ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD.
CONSENT TO DONATE EGGS

(1) I, _____, voluntarily consent and agree to provide my services as a donor of eggs that will be used in connection with assisted reproductive technology procedures carried on at Advanced Reproductive Health Centers, Ltd. ("ARHC").

(2) I consent to be: treated with fertility drugs to assist me in ovulation; monitored frequently using ultrasound to determine development of ovulation; tested frequently for serum (blood) hormone concentration; and, subjected to such other procedures as the members of the assisted reproductive technology medical staff of ARHC determine are appropriate and are subsequently consented to by me. I have also been advised, consent and agree that eggs will be obtained from me surgically by laparoscopic or ultrasound directed follicle aspiration when my ovulation process is at the appropriate stage as determined by the assisted reproductive technology medical staff of ARHC.

(3) I have been informed, consent and agree that the eggs obtained from me will then be donated to a recipient selected by the assisted reproductive technology medical staff of ARHC to be used for the purpose of attempting to establish a pregnancy. I have been informed, consent and agree that the assisted reproductive technology medical staff will attempt to fertilize these eggs with sperm from the recipient's male partner or with donated sperm. I have been informed, consent and agree that if fertilization occurs and embryonic development begins, the embryos produced will be transferred to the uterus of the female recipient.

(4) I have been informed, consent and agree that by signing this Consent to act as a donor, I relinquish all claims to the eggs and any child that results from the use of eggs donated by me. I have been informed, consent and agree that from the moment of retrieval of the eggs, the eggs shall belong to the recipient and that the recipient shall have the sole and exclusive right to determine any medical procedures and treatment regarding the eggs and the recipient. If there are embryos generated in excess of what is safe to transfer to the recipient's uterus at a single time, then the disposition of those embryos will be determined by the recipient. They may be frozen for the recipient's future use or disposed of. I have been informed, consent and agree that the identity of the recipients shall not be disclosed to me unless I have donated eggs for use only by the couple named as follows: _____.

(5) Anonymous donors only: I have been informed, consent and agree that my identity will not be disclosed to the recipient couple. Likewise, I will not be given any information about the identity of the recipients. I have been informed that in certain cases, for medical reasons, it may be necessary for a recipient couple to seek certain

medical information about myself or my family after completion of the cycle. I authorize the assisted reproductive technology medical staff to contact me in the future to ascertain this information. I understand that my anonymity will be maintained.

(6) I consent to a physical examination, including taking blood and other body fluids, as well as a test for exposure to the HIV (AIDS) virus, drug screening, genetic testing and psychological screening for the purpose of giving the assisted reproductive technology medical staff sufficient information to determine whether I am an acceptable egg donor. I have been informed of the potential risks of egg donation and have been given ample opportunity to have my questions answered.

(7) Risks of egg donation include:

- Overstimulation of ovaries, which could result in a feeling of bloating or abdominal discomfort.
- Risks associated with general anesthesia if used in connection with egg retrieval.
- Discomfort, infection and bleeding from laparoscopic or vaginal ultrasound recovery of eggs.
- Pregnancy or multiple pregnancies resulting from having vaginal intercourse during the cycle if adequate contraception is not used.
- Bruising from injections and withdrawal of blood.
- There may be certain long-term risks associated with the use of fertility drugs. These risks include ovarian cyst formation or rupture, ovarian over-stimulation, possible increased risk for ovarian cancer.

(8) I consent and agree that any child born to the recipient or recipient couple shall be deemed the natural child of recipient or recipient couple. I agree that I will undertake no action or proceeding to challenge the legitimacy of any child born to the recipient.

(9) To the best of my knowledge, I have no communicable disease, and do not now, nor have ever suffered any physical or mental impairment or disability, whether inherited or as a result of any disease or ailment.

(10) In connection with providing my services as a donor, I understand and agree:

a) To undergo blood tests for infectious disease, drug screening and hormone levels.
b) To undergo genetic testing for diseases that can be transmitted.
c) To undergo a psychological screening with a psychologist to determine my suitability to be a donor.
d) To take all medication as instructed, including injections of a drug called Lupron (usually self administered) and fertility drugs

(Pergonal and HCG) to stimulate my ovaries to produce several eggs to be retrieved at the time of egg aspiration.

e) To undergo frequent laboratory tests and vaginal ultrasounds in order to be closely monitored.
f) To keep all appointments for all laboratory, vaginal ultrasounds and other tests that are needed.
g) To abstain from intercourse or to use a non-hormonal form of contraception if I do have intercourse, such as condoms or a diaphragm.
h) To notify ARHC if I engage in intercourse with a new partner.
i) To refrain from the use of all recreational drugs and all but occasional alcohol use during my cycle.
j) To report any prescription or non-prescription drug use.
k) To donate my retrieved oocytes (eggs) to a recipient, and I RELINQUISH ANY CLAIM TO OFFSPRING THAT MAY RESULT FROM THE USE OF MY DONATED EGGS FOR IN VITRO FERTILIZATION.
l) I understand that the recipient couple is responsible for any costs and expenses associated with my selection, screening and treatment in connection with the egg donation and retrieval.
m) I understand that I am required to have my own health insurance. In the event that I experience medical complications or require hospitalization, I will be solely liable for the payment of any such expense and neither the recipient couple nor ARHC shall have any liability. Further, I hereby indemnify and hold harmless the recipient couple and ARHC, its officers, directors, shareholders and employees from any such medical and hospital expense arising from any such complication.

(11) I certify that I am at least 21 years of age.

(12) I hereby consent to the donation of my eggs and the procedures described in this consent form. I understand that if I am married that my spouse must also sign this consent form.

Dated:_____ _____
(Name of Donor)

Dated:_____ _____
(Witness)

(13) I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risks attendant to the donation of eggs and I hereby signify my agreement to my spouse's participation in the procedure.

Date:_____ _____
(Name of Spouse)

Date:_____ _____
(Witness)

I, _____, one of the members of the assisted
(Print Name)
reproductive medical staff of ARHC, by my signature, indicates the foregoing consent was read, discussed and signed in my presence.

_____ _____
Signature Date