Reproductive Technologies, Inc.
THE SPERM BANK OF CALIFORNIA
2115 Milvia St., Suite 201, Berkeley, CA 94704 Thespermbankofca.org (510) 841-1858

Requirements for vial transfer of autologous/SIP vials to The Sperm Bank of California

Please complete all areas of information below. Include copies of actual test results.

_____ **Date of Birth: ____/____/_____**

Name of Client Depositor

Total # of .5cc / 1cc vials: _____ Collection Date Range: ____/_____/_____ To ____/____/_____

All tests listed below are required for transfer to TSBC unless identified as optional

Requirements	**Date Completed**	**Status/Result**
Testing Panel		
Blood type/Rh factor		
HIV-1, HIV-2, HIV-O antibody		
HTLV-1 and HTLV-2 antibody		
HIV/HCV/HBV NAT		
Hepatitis B surface antigen		
Hepatitis B core antibody		
Hepatitis C antibody		
Syphilis		
Chlamydia (urethral culture or urine)		
Gonorrhea culture (urethral culture or urine)		
West Nile Virus		
CMV (cytomegalovirus) antibody Total (optional)		
CMV urine (required if CMV IgG positive) (optional)		

I, _____ (print name) certify that the client noted above completed the screening as described above, in compliance with FDA regulations. The semen from this client intended for transfer to TSBC is suitable for donor insemination purposes for autologous use as a **SIP/Client Depositor only.**

Signature _____ Date_____

***Title of Reviewer_____**
****Must be reviewed by medical/ lab personnel***

Name of Clinic/Bank_____ Phone _____

Address _____ City_____ State_____ Zip_____

FDA Registration number _____ ☐ Copies of lab results included