Celebration STEM CELL CENTRE

CSCC ID # Sticker

MATERNAL DEMOGRAPHIC FORM

❒ Public Donation ❒ Private Banking

BABY'S MOTHER'S INFORMATION			
Last Name:		Maiden Name (if applicable):	
First Name:	Middle Name:	Mother's Date of Birth:	
Mailing Address:		Apt/Unit #:	
City:	State:	Zip Code:	Country:
Cell Phone:	Secondary Phone:	Last 4 Digits of Social Security #:	
Email Address:			
Baby's Due Date:	Baby's Name: (if already known)		
Total # of pregnancies:	# of living children:	# of Children Expecting:	

BABY'S FATHER'S INFORMATION			
Last Name:	First Name:	Middle Name:	
Mailing Address (if different than baby's mother's address):		Apt/Unit #:	
City:	State:	Zip Code:	Country:
Cell Phone:	Secondary Phone:	Date of Birth:	
E-mail Address:			

DELIVERING HOSPITAL			
Hospital Name:			
Hospital Address:		Phone:	
City:	State:	Zip:	Country:

OBSTETRICIAN / MIDWIFE INFORMATION			
Physician/Certified Nurse Midwife Name:			
Practice Name:		Phone:	
Address:			
City:	State:	Zip:	Country:

PEDIATRICIAN INFORMATION			
Pediatrician's Name:			
Practice Name:		Phone:	
Address:			
City:	State:	Zip:	Country:

Celebration Stem Cell Centre Private Banking Enrollment Agreement

This Enrollment Agreement (this "Agreement") sets forth the terms and conditions regarding the processing and storage of your unborn baby's umbilical cord blood by Celebration Stem Cell Centre ("CSCC"). Cord blood will be collected by your physician/midwife or nurse using methods approved by CSCC's Medical Director.

I acknowledge and agree that I will be the owner, on my child's behalf, and custodian of the cord blood unit until he or she reaches eighteen (18) years of age. Upon my child reaching eighteen (18) years of age, all ownership rights and claims to the cord blood will vest in such child. At that time, either you or your child may renew this agreement upon written notice to CSCC.

I understand that the initial fee for CSCC's services is $1,975.00. This initial fee includes the cord blood collection kit, all transportation and courier fees for the delivery of the cord blood to CSCC, cord blood processing, testing, cryopreservation and the first-year storage fee. An additional storage fee of $200.00 will be charged annually, beginning one year after the date of initial cryopreservation and on the same day of each subsequent year until this Agreement is terminated.

I agree to pay CSCC the initial fee and the annual storage fees as more specifically described in the Private Banking Enrollment Form attached hereto and by this reference made a part of this Agreement.

In order for CSCC to collect, process and store the umbilical cord blood I agree to fulfill the following responsibilities:

1. Sign and return to CSCC this Enrollment Agreement.
2. Sign and return to CSCC the Celebration Stem Cell Centre Private Cord Blood Banking Informed Consent Agreement.
3. Sign and return to CSCC the hospital/birthing center and physician consent and release form regarding cord blood collection.
4. Complete and return to CSCC the Donor Information and Health History Questionnaire.
5. Sign and return to CSCC the consent form for HIV testing. (All results are confidential.)
6. Provide CSCC with maternal blood (to be drawn during labor and delivery and transported in the cord blood collection kit).
7. Keep CSCC informed of the delivery due date and current contact information.
8. Take the CSCC cord blood collection kit to the hospital/birthing center for use in collection.
9. Contact the CSCC approved medical courier as described in the collection instructions and provided on outside of collection kit.
10. Select a payment plan on the Private Banking Enrollment Form and pay CSCC for all processing and storage services described in this Agreement.

CSCC may choose, at its sole and absolute discretion, not to process and store the cord blood unit if the blood sample or the cord blood unit tests positive for certain viral or bacterial contamination.
I understand that CSCC may be unable to perform its services under this Agreement if my healthcare provider elects not to collect cord blood to protect the health of me or my baby, if the cord blood collected is determined by CSCC to be insufficient in volume, or in the event of loss by a courier, contamination of the cord blood unit, accidents in shipment, misuse, untimely use or incorrect preparation at another facility. There may be other

circumstances beyond CSCC's control that prohibit the collection of the cord blood or blood testing results that preclude the storing of the cord blood. I understand that if any circumstances arise that preclude CSCC from processing and/or storing the cord blood this Agreement will immediately terminate, and CSCC will notify me of the termination of this Agreement in writing describing the reason why CSCC could not process or store the cord blood unit. I further acknowledge and agree that upon such a termination of this Agreement, the Initial Deposit of $150.00 described on the "Private Banking Enrollment Form" will be retained by CSCC for the cost of the collection kit and administrative fees.

I understand that I may terminate this Agreement for any reason by providing CSCC notice in writing with a ("Termination Notice"). Upon my termination of this Agreement, I understand that I have the right to have the cord blood unit transferred to a facility of my choice within 120 days after CSCC's receipt of my Termination Notice, and that if I fail to designate such facility, I agree that all of my ownership rights to the cord blood will be transferred to CSCC. I understand that I am responsible for any expenses incurred by CSCC for transferring the cord blood unit to another facility. I understand further that if I terminate this agreement after CSCC processes the cord blood unit, I will not receive a refund of any fees paid to CSCC under this Agreement, but that I will have no further liability after the date this Agreement terminates for future processing and/or storage fees.

I understand that if I fail to pay CSCC any fees within sixty (60) days of the payment due date, CSCC may immediately terminate this agreement. Upon termination of this agreement for non-payment, all ownership rights to the cord blood unit shall be transferred to CSCC. Neither CSCC nor I will have any continuing obligations to the other after termination of this Agreement, except as specifically provided in this Agreement.

When the cord blood unit is needed for a transplant, I understand that I must provide CSCC with a written request from my physician instructing CSCC to prepare and ship the cord blood unit to the appropriate facility using the delivery service, courier or shipping company designated by me in writing. I understand that if I fail to designate such preferred shipping/delivery service, CSCC shall ship the cord blood in the manner determined at its discretion to provide safe and timely service. In either case, CSCC will prepare and arrange for delivery of the cord blood in accordance with industry standards. I understand and agree that I will be responsible for all shipping and preparation expenses.

I understand that CSCC and the collecting physician (or other practitioner) will be using blood collection systems and equipment made by unrelated suppliers and will utilize the services of third-party transportation couriers. I understand that the cord blood collection will be performed by a physician, nurse or midwife who is not an employee or otherwise affiliated with CSCC, and that the amount of blood collected is variable and cannot be predicted. I understand that there is no guarantee of a successful treatment with stem cells. I am also aware that there is no guarantee that treatment using my baby's umbilical cord blood stem cells will be the most appropriate treatment for any medical condition which arises in the future.

If the cord blood is collected and delivered to CSCC, CSCC agrees to use the proper and customary care under standard processing and storage protocols.

I understand that CSCC shall not be held responsible for damage or loss of the cord blood due to acts of terrorism, civil strife, war, national emergency or acts of God. CSCC will not be liable for anything beyond its direct control including but not limited to: loss by a courier, contamination of the cord blood unit, accidents in shipment, misuse, untimely use, incorrect preparation at other premises, loss of the cord blood due to non-utilization after

thawing, or any other conditions that prevent CSCC from complying with its standard operating procedures and policies. CSCC shall not be liable for any incidental or consequential damages resulting from loss or damage of the cord blood unit. In any event, I agree that CSCC's liability shall be limited solely to a refund of the fees paid for processing and storage of the cord blood.

I have read this Enrollment Agreement and hereby enter into this contractual relationship for the processing and storage of my newborn baby's umbilical cord blood with Celebration Stem Cell Centre. I have selected the desired payment plan and understand the option to prepay the annual storage fee as listed below on the "Private Banking Enrollment Form". I have read and understood all of the terms in this Agreement, the consent documents listed on page one of this agreement and health history questionnaire. I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction. I certify that all of the information I have provided to CSCC is true and correct to the best of my knowledge.

I understand that this Agreement and the legal relations between the parties shall be governed by, and construed and enforced in accordance with, the substantive laws of the State of Arizona, without regard to conflict of laws principles. Any action brought to enforce the terms of this Agreement must be commenced and maintained in the appropriate state or federal court located in Maricopa County, Arizona. This Agreement shall be binding upon, and inure to the benefit of, the parties and their heirs, fiduciaries, successors and assigns. If any provision of this Agreement, or the applicability in any provision to a specific situation, is held to be invalid or unenforceable, the provision shall be modified to the minimum extent necessary to make it or its application valid and enforceable, and the validity and enforceability of all other provisions of this Agreement and all other applications of such provisions will not be affected by any such invalidity or unenforceability.

_____	_____
Print Mother's Full Legal Name	Print Father's Name (optional)
_____	_____
Signature of Mother	Signature of Father (optional)
_____	_____
Date	Date

Private Banking Enrollment Form

Payment Plans:	Payment in full	6 – Month Payment Plan	12 – Month Payment Plan
***All payment plans include cord blood collection kit, courier fees, all blood & cord blood processing and testing, and first year storage.**	Initial Deposit of $150.00 will be charged upon CSCC's delivery of the Collection Kit and applied towards first year costs. $1,825.00 will be charged to credit card account upon CSCC's acceptance of the cord blood.	Initial Deposit of $150.00 will be charged upon CSCC's delivery of the Collection Kit and applied towards first year costs. An additional deposit of $550.00 will be charged to the account upon CSCC's acceptance of the cord blood. **Six equal monthly payments of $235.00** will be charged to the credit card account beginning the month immediately following CSCC's acceptance of the cord blood.	Initial Deposit of $150.00 will be charged upon CSCC's delivery of the Collection Kit and applied towards first year costs. An additional deposit of $550.00 will be charged to the account upon CSCC's acceptance of the cord blood. **Twelve equal monthly payments of $125.00** will be charged to the credit card account beginning the month immediately following CSCC's acceptance of the cord blood.
Collection and Processing Fee:	**$1,975.00**	**$1,975.00**	**$1,975.00**
Interest Charges:	**$0.00**	**$135.00**	**$225.00**
Total Fees: *Including First Year Storage fees	**$1,975.00**	**$2,110.00**	**$2,200.00**
Select Payment Plan:	☐	☐	☐

Cord Tissue Fee: ☐ **$ 600.00 / $200.00 Annual Storage Fee**

Placenta Banking ☐ **$2500.00 /$200.00 Annual Storage Fee**

Multiple Births: ☐

For each additional cord blood collection, a fee of $1,500.00 will be charged. Fee includes an additional cord blood collection kit, courier fees, all blood & cord blood processing and testing, and first year storage.

Total Number of Children:	

***Annual storage fees apply for each child's cord blood unit.**

CORD BLOOD PREPAID STORAGE PLANS:

Prepaid Storage Options:	5 Year Plan:	10 Year Plan:	20 Year Plan:
Storage Plan Description:	Prepay for 5 years of storage and save $100.00 with a one-time payment of $900 at the time of initial processing.	Prepay for 10 years of storage and save $200.00 with a one-time payment of $1,800 at the time of initial processing.	Prepay for 20 years of storage and save $500.00 with a one-time payment of $3,500 at the time of initial processing.
Select a Storage plan:	☐	☐	☐

***If a prepaid storage plan is not selected, $200.00 storage fee will be automatically charged to credit card annually.**

Credit Card Authorization: I hereby authorize Celebration Stem Cell Centre to charge the following credit card account according to the plan(s) selected above. I understand that I am responsible for recurring charges and additional late fees if my credit card is cancelled or otherwise not available for payment. I understand the initial non-refundable deposit of $150.00 will be charged to my credit card upon CSCC's delivery of a collection kit to me. I understand that if either CSCC or I cancel this Agreement prior to processing the cord blood unit for any reason, CSCC will retain the $150.00 deposit to offset the cost of the collection kit and administration fees.

☐ **Visa** ☐ **Master Card** ☐ **American Express** ☐ **Discover**

_____ _____ _____

Card Number 3 Digit Code Expiration Date

_____ _____

Authorized Signature Today's Date

_____

Name as it appears on the card

_____

_____

Billing Address

Celebration Stem Cell Centre, LLC
3495 S. Mercy Rd.
Gilbert, Arizona 85297

CELEBRATION STEM CELL CENTRE
PRIVATE CORD BLOOD BANKING INFORMED CONSENT

1. *PURPOSE*

I understand the service to be provided by Celebration Stem Cell Centre ("CSCC") is to process and store my child's umbilical cord blood after collection by my obstetrician/midwife or a trained collection specialist as more specifically provided in my Enrollment Agreement with CSCC. Cord blood contains sufficient hematopoietic stem cells (the same type of cells found in bone marrow) that may be used for a stem cell transplant to treat some blood disorders or cancer in a child or an adult. CSCC's service involves the processing and storage of umbilical cord blood as an intended alternative source of stem cells. During pregnancy, umbilical cord blood from the placenta provides nutrition and oxygen to the developing fetus. After the baby is delivered and the umbilical cord is clamped and cut, there is excess blood in the cord and placenta which is routinely discarded. By signing this consent, I agree to the processing and storage of my baby's cord blood by CSCC.

2. *YOUR INVOLVEMENT*

I understand that my participation in the processing and storage of my baby's excess umbilical cord blood, and my request for CSCC to perform those services is voluntary. The cord blood will be collected by my obstetrician/midwife and separated from the placenta and cord after my baby is delivered. While waiting for the delivery of the placenta, the cord will be cleansed and the umbilical cord vein will be accessed with a needle to a collection bag. The blood remaining in the placenta and cord will drain by gravity into the collection bag. As the blood is draining, the collection should cause no risk to me or my baby. There is no change in the actual delivery process. My obstetrician/midwife can cancel the cord blood collection at any time if he/she thinks it will expose either me or my baby to any added health risk.

I give permission for a CSCC staff member or approved hospital staff member to review my and my infant's medical records. I will answer a detailed questionnaire about my and my baby's medical history, the biologic family's medical and genetic history and exposures to infectious diseases to the best of my knowledge. I also consent to possible follow-up telephone calls and/or mailings from CSCC to clarify and/or verify health information.

I will also donate a sample of my blood (about four teaspoons). My blood will be tested for infections, including HIV (the AIDS virus), syphilis, hepatitis and other viruses. This testing is important to minimize the risk of transferring diseases with the cord blood if it is later used to treat my child or other blood relative. Some tests may be investigational and not yet approved by the Food and Drug Administration (FDA). The data collected from performing these tests will be used to establish whether continued testing in the future is needed. My baby's cord blood will also be tested for abnormal hemoglobin, such as sickle cell disease and thalassemia. I consent to CSCC reporting abnormal test results to my obstetrician/midwife or my child's pediatrician. I understand that some test results must, under state law, be reported by CSCC to the Arizona Department of Health. CSCC has an obligation to inform me of an abnormal test result that may affect my health or my baby's health so that I may seek appropriate medical care if necessary. I understand that testing could reveal new information that might not have otherwise been discovered and could potentially impact my or my baby's health care now or in the future. The cord blood unit will be tested for cell viability, total number of cells, stem cell concentration levels, blood type and the presence of bacteria and fungi. A cord blood unit may not eligible for use in transplantation if the amount of cord blood collected is too small and/or contains too few cells. If the cord blood unit does not meet size or volume criteria for banking, CSCC will contact me as early as possible and provide me with the option to continue with the processing and storage of the stem cells or to terminate the Enrollment Agreement and make the cord blood unit available for research or validation purposes. If I choose, I may also direct CSCC to dispose of the cord blood product and not use it for research. I understand that cord blood must be processed within 48 hours of collection. CSCC will attempt to contact me within 72 hours to provide me with the option to proceed or terminate the services if CSCC believes that the cord blood does not meet the banking criteria, but CSCC does not guarantee that it will receive my instructions in time to process the cord blood. In that event, CSCC may use the cord blood unit for research or validation purposes.

I understand that in the event my child becomes seriously ill or develops a genetic disorder, illness affecting the immune system or blood related disease, I will notify CSCC as this could impact the blood relative receiving the product for transplantation.

3. *POSSIBLE RISKS AND BENEFITS*

The cord blood is collected after delivery of your baby either while the placenta is still in your body or after it has been delivered. The doctors and nurses have been instructed to never collect the cord blood if the process of collection would expose either you or your baby to any added health risk. There is no change in the actual delivery process. Furthermore, your doctor/midwife can cancel the cord blood collection at any time if he/she thinks it might pose a potential harm to you or your baby.

Blood (about 20 mLs) will be taken from your arm for infectious disease marker tests. This may cause pain, bruising, infection or fainting. The cord blood bank staff may review the hospital medical charts of you and your baby. They will look for prenatal test results including HIV (the virus that causes AIDS), syphilis, and hepatitis tests and other medical information that may be important for determining future use of your baby's cord blood unit.

It is possible that certain medical conditions, which were not apparent at the birth of your baby, may become known to the cord blood bank staff after testing of the cord blood. If they learn about these conditions in the future, they may contact you or your primary physician who may then inform you of the test results. If the infectious disease testing performed on your blood shows that you may have HIV (the

virus that causes AIDS) or hepatitis, you will be informed by your physician or the cord blood bank personnel of these test results. This may cause you to have to deal with health concerns that may or may not happen in the future. In addition, if required by federal, state or local law, some positive results will be reported directly to your state health department. The medical, genetic, sexual and social history questions that are asked are of a sensitive nature. Answering the questions may cause you to feel uncomfortable.

4. CONFIDENTIALITY

The records maintained at CSCC are kept private and confidential. The security of your and your baby's identifying information at CSCC is verified during periodic inspections. Authorized staff from CSCC will have access to your and/or your baby's personal information. Additionally, authorized CSCC staff, the American Association of Blood Banks (AABB) and the FDA will have access to you and/or your baby's medical charts (i.e., the medical charts maintained on you and your baby as a donor) for inspections or audits. By signing this consent form, you consent to such inspections and to the copying of excerpts from your and your baby's donor medical charts, if required to meet regulatory requirements. CSCC will not disclose any information about your or your baby by any means of communication to any person or organization, except by your written request or permission, or unless required by federal, state or local laws, or regulatory agencies, or except as disclosed in this consent form.

5. OWNERSHIP, TRANSFER AND DISPOSITION

I understand that I hold all ownership rights to the cord blood unit on behalf of my child, as provided in the Enrollment Agreement. If I no longer wish my baby's cord blood unit to be stored, I must provide in writing to CSCC a written request to discontinue service and terminate the Enrollment Agreement. If I terminate the Enrollment Agreement, I have the right to (a) have the cord blood unit transferred to a facility of my choice within 120 days, (b) require that CSCC discard the cord blood unit, or (c) transfer all ownership rights to CSCC. I understand that I am responsible for any expenses for transferring the cord blood unit to another facility, and I will not receive any fee refund if I terminate the Enrollment Agreement after the cord blood unit is processed, as more specifically described in the Enrollment Agreement. Unless I specify otherwise in writing, CSCC will make my baby's cord blood unit available for research or validation purposes upon termination of the Enrollment Agreement. If I request my baby's cord blood unit to be discarded, CSCC will discard the cord blood unit according to approved CSCC standard operating procedures and any applicable laws or regulations.

6. ASSOCIATED COSTS

The initial fee for CSCC's services is $1,975.00. This fee includes the cord blood collection kit, all transportation and courier fees, cord blood processing, testing, cryopreservation and first year storage. An additional storage fee of $150.00 will be charged annually, beginning one year after the date of initial cryopreservation and subsequent years until the Enrollment Agreement is terminated as more specifically described in the Celebration Stem Cell Centre Enrollment Agreement and Private Banking Enrollment Form. Additional fees will apply if banking for multiple births. I agree to pay CSCC all fees as described in the Private Banking Enrollment Form and I understand that CSCC may terminate its services if I fail to make any payment within 60 days after a payment due date.

7. QUESTIONS OR CONCERNS

If you have any questions or concerns about your relationship with CSCC you may contact CSCC's Laboratory Director or Medical Director at 1-877-522-2355.

8. STATEMENT OF CONSENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS CONSENT FORM, YOU HAVE BEEN PROVIDED INFORMATION CONCERNING THE RISKS, BENEFITS, AND ALTERNATIVES TO CORD BLOOD DONATION AND YOU HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND YOUR QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. YOU AGREE TO THE TERMS AND CONDITIONS OF THE SERVICE.

Mother Sign Here

Signature of the Mother on behalf of her baby as Donor **Date**

Print Name of Mother

Person Authorized Pursuant to Law to Consent to Health Care for the Expectant Mother (if Expectant Mother is a minor):

Signature *Date*

Print Name *Relationship to Expectant Mother*

Use of an Interpreter: Complete if the subject is not fluent in English and an interpreter was used to obtain consent.

Print name of interpreter: _____ Date: _____

Signature of interpreter: _____

An oral translation of this document was administered to the subject in _____ (state language) by an individual proficient in English and _____ (state language). See the attached addendum for documentation.

Certification of Physician/Hospital/Birthing Center Staff

I hereby certify that the nature and purpose, the potential benefits, and possible risks associated with the collection, processing, storage and use of cord blood banking have been explained to the above individual and that any questions about this information have been answered.

_____ _____ Physician Sign Here

Counseling Healthcare Professional Date

Celebration Stem Cell Centre, LLC
3495 S. Mercy Rd.
Gilbert, Arizona 85297

CELEBRATION STEM CELL CENTRE
INFORMED CONSENT FOR PRIVATE STORAGE AND HOSPITAL/BIRTHING CENTER RELEASE

I desire the collection of my unborn baby's cord blood for donation or storage. I have elected to utilize the services of Celebration Stem Cell Centre to achieve the desired donation/storage. For the donation/storage to occur it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my baby, rather than discard them as medical waste. The collected cord blood will be shipped to Celebration Stem Cell Centre for processing and placement into storage.

My physician, physician's designee, midwife or a Celebration Stem Cell Centre trained collection specialist will perform the collection of the cord blood after the delivery of my baby at the same time the placenta is being delivered. He/she will use methods provided by Celebration Stem Cell Centre. My physician may decide that a medical condition that occurs during or after delivery makes collection of cord blood impossible, and if that happens I cannot donate cord blood.

I understand that the donation/storage of cord blood includes medical procedures and there can be no guarantee or assurance of success of the results of the service. I further, on behalf of myself and my unborn baby, our respective heirs, successors and assigns, hereby release and forever hold harmless the Hospital/Birthing Center, and its affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of action, claims, debts, demands, liabilities, covenants, controversies, omissions and damages and any and all other claims of every kind, nature and description whatsoever, both in law and equity, which may arise relating to the collection of the cord blood on behalf of me and my baby.

Mother Print Here

Print Name of Expectant Mother

Signature of Expectant Mother Date

Mother Sign Here

Person Authorized Pursuant to Law to Consent to Health Care for the Expectant Mother (if Expectant Mother is a minor):

Print Name of Authorized Person

Signature of Authorized Person

Date

Relationship to Expectant Mother

PHYSICAN-DONATED SAMPLE

My patient desires the collection of her unborn baby's cord blood for donation/storage at Celebration Stem Cell Centre. For the donation to occur it is necessary to collect and save the blood from the placenta and umbilical cord after the birth of my patient's baby, rather than discarding the blood as medical waste. The cord blood obtained will be shipped to Celebration Stem Cell Centre for processing and placement into storage.

I, or a Celebration Stem Cell Centre trained and approved collection specialist, will perform the collection of the cord blood after the birth of her baby while the delivery of the placenta occurs. The collection will use the methods provided by Celebration Stem Cell Centre in their standard operating procedures. The collection period will be brief and Celebration Stem Cell Centre will provide the protocols and collection equipment in the cord blood collection kit. Every effort will be made to acquire as much cord blood as is feasible and to minimize the risk of fungal, bacterial, or maternal blood contamination.

The health and welfare of my patient and her baby are my primary concern and responsibility. Accordingly, I reserve the right to forgo the collection of the cord blood if my best medical judgment indicates this to be necessary.

I understand that the donation/storage of cord blood includes medical procedures and that there can be no guarantee or assurance of success of results of the service. I, on behalf of myself, my heirs and successors and assigns hereby release and forever discharge Celebration Stem Cell Centre and its affiliates, successors, assigns, officers, directors, employees and agents from any and all actions, causes of actions, demands, debts, claims liabilities, covenants and damages and any and all other claims of every kind, nature and description whatever both in law and equity which may arise relating to my performing the collection of the cord blood.

Celebration Stem Cell Centre on behalf of its affiliates, assigns, officers, directors, employees and agents releases and forever discharges me and each of my heirs, successors and assigns from any and all actions, causes of actions, demands, debts, claims, liabilities, covenants and damages and any and all other claims of every kind, nature and description whatever, both in law and equity, which may arise relating to my performing the collection of the cord blood

Physician Print Here

Print Name (Physician/Midwife/PA/NP)

Signature of Physician/Midwife/PA/NP Date

Physician Sign Here

Celebration Stem Cell Centre, LLC
3495 S. Mercy Rd.
Gilbert, Arizona 85297

CELEBRATION STEM CELL CENTRE
INFORMED CONSENT FOR PRIVATE STORAGE AND HOSPITAL/BIRTHING CENTER RELEASE

IMPORTANT: THIS FORM IS REQUIRED TO BE SIGNED BY YOU AND YOUR PHYSICIAN/MIDWIFE IN ORDER TO RECEIVE A CELEBRATION STEM CELL CENTRE CORD BLOOD COLLECTION KIT. TO AVOID ANY DELAYS IN YOUR PAPERWORK REVIEW, PLEASE ENSURE THAT ALL REQUIRED SIGNATURES ARE PRESENT PRIOR TO SUBMITTING YOUR COMPLETED FORMS.

Celebration Stem Cell Centre, LLC
3495 S. Mercy Rd.
Gilbert, Arizona 85297

Celebration STEM CELL CENTRE

CSCC ID # Sticker

BABY'S RACE AND ETHNICITY INFORMATION

Since certain HLA types may be more common in each ethic group, the information below will help in selecting a cord blood unit for transplant.

BABY'S ETHNICITY:

RESPONSE IS REQUIRED, PLEASE CHECK ONE: ❒ **HISPANIC OR LATINO** ❒ **NOT HISPANIC OR LATINO**

BABY'S RACE:

Of which group(s) is your baby a member? (Select all that apply.)

American Indian or Alaska Native
- ❒ Alaska Native or Aleut (ALANAM)
- ❒ North American Indian (AMIND)
- ❒ American Indian South or Central American (AMIND)
- ❒ Caribbean Indian (AMIND)

Black or African American
- ❒ African (AFB)
- ❒ African American (AAFA)
- ❒ Black Caribbean (CARB)
- ❒ Black South or Central American (SCAMB)

Asian
- ❒ Chinese (NCHI)
- ❒ Filipino (Philipino) (FILI)
- ❒ Japanese (JAPI)
- ❒ Korean (KORI)
- ❒ South Asian (SCSEAI)
- ❒ Vietnamese (SCSEAI)
- ❒ Other Southeast Asian (SCSEAI)

Native Hawaiian or Other Pacific Islander
- ❒ Guamanian (OPI)
- ❒ Hawaiian (HAWI)
- ❒ Samoan (OPI)
- ❒ Other Pacific Islander (OPI)

White
- ❒ Eastern European (CAU) □ Northern European (CAU)
- ❒ Mediterranean (CAU) □ Western European (CAU)
- ❒ Middle Eastern (MENAFC) □ White Caribbean (CAU)
- ❒ North Coast of Africa (MENAFC) □ White South or Central American (CAU)
- ❒ North American (CAU) □ Other White (CAU)

SIGNATURE

I have received information from the cord blood bank necessary to complete the following forms:

- Maternal Demographic Information
- Maternal Risk Questionnaire
- Family Medical History Questionnaire

I have completed these forms to the best of my knowledge. I understand that only authorized staff from the cord blood bank will have access to my personal information.

Forms completed by:

_____ Today's Date:_____

Signature

Thank you for donating your baby's cord blood. The blood in the umbilical cord and placenta is unique because it contains a large number of blood-forming cells. Seriously ill patients, whose bodies cannot make healthy cells of their own, can be helped by a donation of healthy cord blood cells from a matched unit. Cord blood donations give more patients hope of finding a match.

In the event that an illness affecting the immune system or a blood related disease should develop in your baby, or if you learn of a reason which would exclude you from donating or feel that it should not be transfused to a patient, please call Celebration Stem Cell Centre: (480) 722-9963 or toll-free at 1-877-522-2355.

Celebration STEM CELL CENTRE

MATERNAL RISK AND FAMILY MEDICAL HISTORY QUESTIONNAIRE

CSCC ID# Label

MATERNAL RISK QUESTIONNAIRE

Please ***read carefully*** and answer the following questions "YES" or "NO".

1.	Have you ever donated or attempted to donate cord blood using your current or a different name to this cord blood bank?	❒ Yes	❒No
2.	Have you, for any reason, been deferred or refused as a blood or cord blood donor, or been told not to donate blood or cord blood? ***If yes***, why?_____	❒ Yes	❒No
3.	Are you know taking or have you ever taken any of the following medications? (check all that apply):		
	a. Insulin from cows (bovine or beef insulin)?.....	❒ Yes	❒No
	b. Growth hormone from human pituitary glands ever?.....	❒ Yes	❒No
	c. Rabies vaccination in the past year?.....	❒ Yes	❒No
	d. Hepatitis B Immune Globulin?.....	❒ Yes	❒No
	e. Unlicensed Vaccine?.....	❒ Yes	❒No
4.	Are you currently taking an antibiotic?	❒ Yes	❒No
5.	Are you currently taking any other medication for an infection?	❒ Yes	❒No
6	**In the past 8 weeks,** have you had any vaccinations or other shots? ..... ***If yes***, please describe: _____	❒ Yes	❒No
7.	**In the past 12 weeks**, have you had contact with someone who had a smallpox vaccine?..... (Examples of contact include physical intimacy, touching the vaccination site, touching the bandages or covering of the vaccination site, or handling bedding or clothing that had been in contact with an unbandaged vaccination site.)	❒ Yes	❒No
8.	**In the past 4 months,** have you experienced **two (2)** or more of the following: a fever (>100.5°F or 38.06°C), headache, muscle weakness, skin rash on trunk of the body, or swollen lymph glands? ..... **If yes**, which symptoms and when? Please specify: _____	❒ Yes	❒No
9.	Have you ever had any type of cancer, including leukemia?..... ***If yes,*** please describe:_____	❒ Yes	❒No
10.	**In the past 5 years**, have you had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates?	❒ Yes	❒No
11.	**In the past 12 months,** have you been told by a healthcare professional that you have West Nile Virus infection or received any positive test for West Nile Virus?	❒ Yes	❒No
12.	Have you ever had a diagnosis of clinical, symptomatic viral hepatitis after age 11?	❒ Yes	❒No
13.	Have you ever had a parasitic blood disease (for example, Leishmaniasis, Babesiosis, Chagas disease)or any positive tests for Chagas or T. cruzi, including screening tests?	❒ Yes	❒No
14.	Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), variant CJD, dementia, any degenerative or demyelinating disease of the central nervous system, or other neurological disease?	❒ Yes	❒No
15.	Have any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), or have you been told that your family has an increased risk for CJD?	❒ Yes	❒No
16.	Have you received a dura mater (brain covering) graft?	❒ Yes	❒No
17.	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	❒ Yes	❒No

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MATERNAL RISK AND FAMILY MEDICAL HISTORY QUESTIONNAIRE

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18.	Have you ever lived with or had sexual contact with anyone who had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	❒ Yes	❒No
	In the past 3 years:		
	19. Have you had malaria?	❒ Yes	❒No
	20. Have you been outside the United States or Canada?	❒ Yes	❒No
	If yes, please list ***where***, ***when***, and for ***how long***:_____		
21.	**In the 12 months prior to the collection of the cord blood unit**, have you had a blood transfusion?	❒ Yes	❒No
	In the past 12 months:		
	22. Have you had a transplant or tissue graft from someone else such as organ, bone marrow, stem cell, cornea, bone, skin, or other tissue?	❒ Yes	❒No
	23. Have you had a tattoo or ear, skin, or body piercing?	❒ Yes	❒No
	If yes, answer question 22. **If no**, skip to question 23.		
	24. Were shared or non-sterile inks, needles, instruments, or procedures used for the tattoo or piercing?	❒ Yes	❒No
	25. Have you had an accidental needle stick, or have you come into contact with someone else's blood through an open wound (for example, a cut or sore), non-intact skin, or mucous membrane (for example, into your eye, mouth, etc.)?	❒ Yes	❒No
	26. Have you had or been treated for a sexually transmitted disease, including syphilis?	❒ Yes	❒No
	27. Have you given money or drugs to anyone to engage in sex with you?	❒ Yes	❒No
	28. Have you engaged in sex with anyone who had taken money or drugs for sex in the **past 5 years**?	❒ Yes	❒No
	29. Have you had sexual contact or lived with a person who has active or chronic viral Hepatitis B or Hepatitis C?	❒ Yes	❒No
	30. Have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else <u>not</u> prescribed by a doctor in the **past 5 years**?	❒ Yes	❒No
	31. Have you had sex with a male who has had sex with another male, even once, in the **past 5 years**?	❒ Yes	❒No
	32. Have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem in the **past 5 years**?	❒ Yes	❒No
	33. Have you had sex, even once, with anyone who has HIV/AIDS or had a positive test for the AIDS virus?	❒ Yes	❒No
	34. Have you been in juvenile detention, lockup, jail or prison for more than **<u>72 continuous hours</u>**?	❒ Yes	❒No
	In the past 5 years:		
	35. Have you engaged in sex in exchange for money or drugs?	❒ Yes	❒No
	36. Have you used a needle, even once, to take drugs, steroids or anything else <u>not</u> prescribed for you by a doctor?	❒ Yes	❒No
37.	Do you have AIDS or have you ever tested positive for HIV (including screening tests)?	❒ Yes	❒No

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38.	**Do you have any of the following:**		
	38a. Unexplained night sweats?	❒ Yes	❒No
	38b. Unexplained blue or purple spots on or under the skin or mucous membrane?	❒ Yes	❒No
	38c. Unexplained weight loss?	❒ Yes	❒No
	38d. Unexplained persistent diarrhea?	❒ Yes	❒No
	38e. Unexplained cough or shortness of breath?	❒ Yes	❒No
	38f. Unexplained temperature higher than 100.5°F (38.06°C) for more than 10 days?	❒ Yes	❒No
	38g. Unexplained persistent white spots or sores in the mouth?	❒ Yes	❒No
	38h. Multiple lumps in your neck, armpits, or groin lasting longer than one month?	❒ Yes	❒No
	38i. Any infections during your pregnancy?	❒ Yes	❒No
39.	Have you ever tested positive for HTLV (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)? HTLV refers to Human T-cell Lymphotrophic Virus.	❒ Yes	❒No
40.	If a person has the AIDS virus, do you understand that the person **<u>can give it to someone else</u>** even though they may feel well and have a negative AIDS test?	❒ Yes	❒No

For Questions 41 through 50 please refer to the charts below for a list of countries involved:

Albania	France	Netherlands (Holland)	Switzerland	Yugoslavia (Federal Republic of)
Austria	Germany	Norway	United Kingdom (UK)	Kosovo
Belgium	Greece	Poland	England	Montenegro
Bosnia-Herzegovina	Hungary	Portugal	Northern Ireleand	Serbia
Bulgaria	Ireland (Republic of)	Romania	Scotland, Wales	
Croatia	Italy	Slovak Republic	The Isle of Man	
Czech Republic	Liechtenstein	Slovenia	The Channel Islands	
Denmark	Luxembourg	Spain	Gibralter	
Finland	Macedonia	Sweden	The Falkland Islands	

41. **Since 1980, have you ever lived in or traveled to Europe? *(refer to chart above).* If yes,** answer questions **42** through **45**. **If no**, skip question **48**	❒Yes	❒No
42. **From 1980 through 1996,** did you spend time that adds up to 3 months or more in the United Kingdom (refer to chart above)?	❒Yes	❒No
43. **Since 1980,** have you received a transfusion of blood or blood components while in the UK or France?	❒Yes	❒No
44. **Since 1980,** have you spent time that **adds up to 5 years or more** in Europe (refer to chart above), including time spent in UK between 1980 and 1996?	❒Yes	❒No
45. **From 1980 through 1996,** were you a member of the U.S. military, a civilian military employee, or a dependent of a member of the U.S. military or civilian military employee? **If yes**, answer **46**and **47**. **If no**, skip to question **48**	❒Yes	❒No
46. **From 1980 through 1990,** did you spend **<u>a total of 6 months or more</u>** associated with a military base in any of the following countries: UK, Belgium, Netherlands or Germany?	❒Yes	❒No
47. **From 1980 through 1996,** did you spend a **<u>total of 6 months or more</u>** associated with a military base in any of the following countries: Spain, Portugal, Turkey, Italy or Greece?	❒Yes	❒No

Reference Guide for Questions 46 – 48: <u>African Countries</u>

Benin	Central African Republic	Congo	Gabon	Niger	Senegal	Zambia
Cameroon	Chad	Equatorial Guinea	Kenya	Nigeria	Togo	

48. **Since 1977,** were you born in, have you lived in, or have you traveled to any African country listed above?	❒Yes	❒No

If yes, answer question 49. ***If no***, skip to question **50.**		
49. While in one of the African countries listed above, did you receive a blood transfusion or any other medical treatment with a product made from blood?	❒Yes	❒No
50. Have you had sexual contact with anyone who was born in or lived in any African country listed above **since 1977**?	❒Yes	❒No

FAMILY MEDICAL HISTORY QUESTIONNAIRE

1.	Were you and/or the baby's father adopted at early childhood?	❒Yes	❒No
	1a. ***If yes,*** is a family medical history available for you and/or the baby's father?	❒Yes	❒No
2.	Are you and the baby's father related, except by marriage? (e.g. first cousins)	❒Yes	❒No
3.	Did this pregnancy either use a donor egg or donor sperm?	❒Yes	❒No
	3a. ***If yes***, is a family medical history questionnaire available for the egg or sperm donor? (please attach copy)	❒Yes	❒No
4.	Have you ever had an abnormal result from a prenatal test (e.g. amniocentesis, blood test, ultrasound)?	❒Yes	❒No
	If yes, answer the following questions. ***If no***, skip to questions **5.**		
	4a. Which test was abnormal?_____		
	4b. What was the abnormal test result?_____		
	4c. Was a diagnosis made?	❒Yes	❒No
	If yes, specify diagnosis:_____		
5.	Have you had any children who died within the first 10 years of life?	❒Yes	❒No
	5a. ***If yes,*** what was the cause?_____		
6.	Have you ever had a stillborn child?	❒Yes	❒No
	6a. ***If yes,*** what was the cause?_____		

For the remainder of the questionnaire, describe the relationship between the baby and the immediate family member with the disease. Please refer to the following codes:

Family Relationship Codes: **BM** Baby's Mother **BF** Baby's Father **BGP** Baby's Grandparent **BS** Baby's sibling **BMS** Baby's Mother's Sibling* **BFS** Baby's Father's Sibling *

*(Parent's sibling (BMS and BFS) refer to the baby's aunts and uncles by blood, and does not include aunts and uncles who are in-laws of the parents).

7.	**Cancer or Leukemia?**	❒Yes	❒No			
	If yes, please specify all that apply in **7A-7J**. ***If no***, skip to question **8.**	**BM**	**BF**	**BS**		
	7a. Brain or other nervous system cancer	❒	❒	❒	**IMMEDIATE FAMILY ONLY**	
	7b. Bone or joint cancer	❒	❒	❒		
	7c. Kidney (including renal pelvic) cancer	❒	❒	❒		
	7d. Thyroid Cancer	❒	❒	❒		
	7e. Hodgkin's Lymphoma	❒	❒	❒		
	7f. Non-Hodgkin's Lymphoma	❒	❒	❒		
	7g. Acute or chronic myelogenous/myeloid leukemia	❒	❒	❒		
	7h. Acute or chronic lymphocytic/lymphoblastic leukemia	❒	❒	❒		
	7i. Skin Cancer	❒	❒	❒		

	7j. Other cancer/leukemia..... Specify Type:_____ Specify Type:_____	❒	❒	❒					
Answer Questions **8-12** for any Blood Disorders or Diseases. ***If yes,*** please specify as applicable.									
8.	**Red Blood Cell Disease?** ❒Yes ❒No								
	If yes, please specify that all apply in **8a-8d.** If no, skip to question **9.**	**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**		
	8a.. Diamond-Blackfan Syndrome.....	❒	❒	❒	❒	❒	❒		
	8b. Elliptocytosis.....	❒	❒	❒	❒	❒	❒		
	8c. Spherocytosis.....	❒	❒	❒	❒	❒	❒		
	8d. G6PD or other red cell enzyme deficiency.....	❒	❒	❒	❒	❒	❒		
9.	**White Blood Cell Disease?** ❒Yes ❒No								
	If yes, please specify all that apply in **9a-9d.** ***If no,*** skip to question **10.**	**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**		
	9a. Chronic Granulomatous Disease.....	❒	❒	❒	❒	❒	❒		
	9b. Kostmann Syndrome.....	❒	❒	❒	❒	❒	❒		
	9c. Schwachman-Diamond Syndrome.....	❒	❒	❒	❒	❒	❒		
	9d. Leukocyte Adhesion Deficiency (LAD).....	❒	❒	❒	❒	❒	❒		
10.	**Immune Deficiencies?** ❒Yes ❒No								
	If yes, please specify all that apply in **10a-10h.** If no, skip to question **11.**	**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**		
	10a. ADA or PNP Deficiency.....	❒	❒	❒	❒	❒	❒		
	10b. Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID).....	❒	❒	❒	❒	❒	❒		
	10c. DiGeorge Syndrome.....	❒	❒	❒	❒	❒	❒		
	10d. Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL.....	❒	❒	❒	❒	❒	❒		
	10e. Hypoglobulinemia.....	❒	❒	❒	❒	❒	❒		
	10f. Nezeloff Syndrome.....	❒	❒	❒	❒	❒	❒		
	10g. Severe Combined Immunodeficiency.....	❒	❒	❒	❒	❒	❒		
	10h. Wiskott-Aldrich Syndrome.....	❒	❒	❒	❒	❒	❒		
11.	**Platelet Disease?** ❒Yes ❒No								
	If yes, please specify all that apply in **11a-11g.** ***If no***, skip to question **12.**	**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**		
	11a. Amegakaryocytic Thrombocytopenia.....	❒	❒	❒	❒	❒	❒		
	11b. Glanzmann Thrombasthenia.....	❒	❒	❒	❒	❒	❒		
	11c. Hereditary Thrombocytopenia.....	❒	❒	❒	❒	❒	❒		
	11d. Platelet Storage Pool Disease.....	❒	❒	❒	❒	❒	❒		
	11e. Thrombocytopenia with absent radii (TAR).....	❒	❒	❒	❒	❒	❒		
	11f. Ataxia-Telangiectasia.....	❒	❒	❒	❒	❒	❒		

	11g. Fanconi Anemia.....			❒	❒	❒	❒	❒	❒
12.	**Other blood disease or disorder?** Specify type:_____	❒Yes	❒No	❒	❒	❒	❒	❒	❒
Hemoglobin Problems				**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
13.	Sickle cell disease, such as sickle-cell anemia or sickle thalassemia? Specify disease:_____	❒Yes	❒No	❒	❒	❒	❒	❒	❒
14.	Thalassemia, such as alpha thalassemia or beta-thalassemia?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
15.	**Metabolic/Storage Disease?**	❒Yes	❒No						
	If yes, please specify all that apply in **15a-15q**. If no, skip to question **16.**			**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
	15a. Hurler Syndrome (MPS I).....			❒	❒	❒	❒	❒	❒
	15b. Hurler-Scheie Syndrome (MPS I H-S).....			❒	❒	❒	❒	❒	❒
	15c. Hunter Syndrome (MPS II).....			❒	❒	❒	❒	❒	❒
	15d. Sanfilippo Syndrome (MPS III).....			❒	❒	❒	❒	❒	❒
	15e. Morquio Syndrome (MPS IV).....			❒	❒	❒	❒	❒	❒
	15f. Maroteaux-Lamy Syndrome (MPS VI).....			❒	❒	❒	❒	❒	❒
	15g. Sly Syndrome (MPS VII).....			❒	❒	❒	❒	❒	❒
	15h. I-cell disease.....			❒	❒	❒	❒	❒	❒
	15i. Globoid Leukodystrophy (Krabbe Disease).....			❒	❒	❒	❒	❒	❒
	15j. Metachromatic Leukodystrophy (MLD).....			❒	❒	❒	❒	❒	❒
	15k. Adrenoleukodystrophy (ALD).....			❒	❒	❒	❒	❒	❒
	15l. Sandhoff Disease.....			❒	❒	❒	❒	❒	❒
	15m. Tay-Sachs Disease.....			❒	❒	❒	❒	❒	❒
	15n. Gaucher Disease.....			❒	❒	❒	❒	❒	❒
	15o. Niemann Pick-Disease.....			❒	❒	❒	❒	❒	❒
	15p. Porphyria.....			❒	❒	❒	❒	❒	❒
	15q. Other or unknown metabolic/storage disease..... Specify type:_____			❒	❒	❒	❒	❒	❒
Acquired Immune System Disorders				**BM**	**BF**	**BS**	**IMMEDIATE FAMILY ONLY**		
16.	**HIV/AIDS?**	❒Yes	❒No	❒	❒	❒			
17.	**Severe autoimmune disorder?**	❒Yes	❒No	❒	❒	❒			
	If yes, please specify all that apply in questions **17a-17d.** ***If no***, skip to question **18.**			**BM**	**BF**	**BS**			
	17a. Crohn's Disease or Ulcerative Colitis.....			❒					
	17b. Lupus.....			❒					
	17c. Multiple Sclerosis (MS).....			❒					
	17d. Rheumatoid Arthritis.....			❒					

18.	Any other or unknown immune system disorders? Specify Disorder:_____	❒Yes	❒No	❒	❒	❒			
Answer Questions 19-25				**BM**	**BF**	**BS**	**BGP**	**BMS**	**BFS**
19.	Required chronic blood transfusions?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
20.	Have you been told you or your family member(s) have hemolytic anemia?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
21.	Had spleen removed to treat a blood disorder?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
22.	Had gallbladder removed before age of 30?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
23.	Had Creutzfeldt-Jakob Disease (CJD)?	❒Yes	❒No	❒	❒	❒	❒	❒	❒
24.	Other serious or life-threatening diseases affecting the family?..... ***If yes,*** list affected family member(s) and type of disease. Specify Type:_____ Specify Type:_____ Specify Type:_____	❒Yes	❒No	 ❒ ❒ ❒	 ❒ ❒ ❒	 ❒ ❒ ❒	 ❒ ❒ ❒	 ❒ ❒ ❒	 ❒ ❒ ❒
25.	In answering these questions, have you answered for both your family and the baby's father's family?	❒Yes	❒No						

Addendum A: Zika Virus			
1.	Have you had a medical diagnosis of ZIKV infection **at any point** during your pregnancy?	❒Yes	❒No
2.	Have you resided in, or traveled to, an area with active ZIKV transmission* **at any point** during your pregnancy?	❒Yes	❒No
3.	Have you had sex during your pregnancy with a male who is known to have: a. A medical diagnosis of ZIKV within the six months prior to the contact b. Resided in, or traveled to, an area with active ZIKV transmission* within the six months prior to that contact i. Country(ies) traveled to:_____ ii. Date(s) of travel:_____	❒Yes	❒No
Addendum B: Mycobacterium Tuberculosis			
1.	Have you ever had a positive test for tuberculosis (TB) infection (including a positive skin test, blood test, or sputum test)?	❒Yes	❒No
2.	Have you ever had a medical diagnosis of TB disease or infection?	❒Yes	❒No
3.	Have you ever had a diagnosis of latent TB infection (LTBI)?	❒Yes	❒No
4.	Were you born in an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	❒Yes	❒No
5.	Have you ever lived in an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	❒Yes	❒No

6.	Have you ever traveled to an area of the world where TB is common (e.g., Latin American countries, the Caribbean, Africa, Asia, Eastern Europe, Russia)?	❒Yes	❒No
7.	Have you ever lived in a jail, prison, or correctional facility?	❒Yes	❒No
8.	Have you ever worked in a jail, prison, or correctional facility?	❒Yes	❒No
9.	Have you ever lived in a long-term care facility, or homeless shelter?	❒Yes	❒No
10.	Have you ever worked in a long-term care facility, or homeless shelter?	❒Yes	❒No
11.	Have you ever lived with (resided in the same dwelling) another person who has TB?	❒Yes	❒No
12.	Have you ever been a close contact of another person with TB?	❒Yes	❒No
13.	Do you have a medical condition that can impair your immune function (e.g., diabetes, chronic kidney disease/end stage renal disease with or without dialysis)?	❒Yes	❒No
14.	Are you taking medications that can impair your immune function?	❒Yes	❒No
	Addendum C: Sepsis		
1.	Do you currently have a medical diagnosis of sepsis or suspicion of sepsis?	❒Yes	❒No

Consenter Review (if applicable):

Reviewed by: _____ **Date** _____

TO BE COMPLETED BY CELEBRATION STEM CELL CENTRE:

I have reviewed the above responses and have determined all requirements met and responses are acceptable: ❒Yes ❒No

If NO, specify reason: _____

Reviewed by: _____ **Date** _____

Ineligible Donor Statement:
Based on information noted above, this donor is determined to be ineligible to donate her cord blood product.

Medical Director, Celebration Stem Cell Centre: _____ **Date** _____

Celebration STEM CELL CENTRE

CSCC ID # Label

CELEBRATION STEM CELL CENTRE
HIV TEST INFORMED CONSENT

HUMAN IMMUNODEFICIENCY VIRUS AND TRANSMISSION:

Human Immunodeficiency Virus (HIV) is a virus which can be transmitted from individuals through body fluids, primarily blood and semen. The spread is not through air or food or by casual social contact. It is passed on when the blood or body fluids of an infected person mix with your own. Being infected with HIV through sexual contact mainly happens by having contact with semen of a person who has HIV. Women, as well as men, can infect their sexual partners with the virus. The HIV virus has also been found in vaginal secretions, tears, and saliva, but there is no proof that HIV can spread by contact with saliva. Intravenous drug users and persons receiving blood transfusions can be exposed to the virus through infected blood or body products. A baby may become infected during pregnancy, delivery, or when breast feeding if its mother has the disease. A person may carry the virus for months before testing positive and may carry the virus for months or years before any symptoms appear. A person with HIV can still spread the disease even though he or she may appear healthy.

When HIV enters the blood stream it invades and destroys cells in the body's infection and cancer fighting system and reduces the body's ability to fight infections. The HIV virus attacks the immune system, so that infections which one wouldn't normally get (opportunistic infections) start developing, and then the infected person has Acquired Immunodeficiency Syndrome (AIDS). The HIV virus is not what kills a person with AIDS; it is the opportunistic infections which cause death.

BEHAVIORS THAT INCREASE YOUR RISK OF BEING EXPOSED TO HIV:

Recent blood, plasma, or blood product transfusion, intravenous drug use, especially with sharing of needles or syringes, or having sexual contact with someone who: (a) has tested positive for HIV infection, (b) is at risk of infection through his or her own sexual practices, (c) uses IV drugs, or had a recent blood transfusion, (d) uses illicit intravenous drugs, (e) received blood transfusions, plasma, or clotting factor before 1985, (f) within the last twelve months, has more than one sexual partner, especially partners who could be at risk of HIV infection, or (g) is a man who has had sexual relations with another man.

THE HIV TEST AND VOLUNTARY TESTING

The HIV tests are blood tests for the presence of the HIV virus and antibodies to the HIV virus. A positive test result means that you have been exposed to the virus, and either have made antibodies or are infected. It may not mean that you have AIDS now or that you will become sick with AIDS in the future. A negative test means that you are probably not infected with the virus. It takes about 12 days to detect the virus from time of infection to time of detection. Please note, if you do not wish to have your blood tested for HIV, you will not be eligible to donate your baby's cord blood.

CONSENT

Taking the HIV test is voluntary, and results are confidential by law. Results can only be given to people you allow, and a release form must be signed prior to releasing this information. The law requires Celebration Stem Cell Centre to report any positive HIV test result to the Arizona Department of Health or state equivalent if not in Arizona.

I have read the above information and have had my questions about the test answered. I agree to take the HIV test. I allow the test results to be made available to Celebration Stem Cell Centre and to private physician(s):

Dr._____. Physician's Name

_____ _____ Mother Sign Here

Signature of Expectant Mother **Date**

_____ Mother Print Here

Print Name (Expectant Mother)

Person Authorized Pursuant to Law to Consent to Health Care for the Expectant Mother
(if Expectant Mother is a minor or unable to sign)

_____ _____

Signature Date

_____ _____

Print Name Relationship to Expectant Mother

Celebration Stem Cell Centre, LLC
3495 S. Mercy Rd.
Gilbert, Arizona 85297

Celebration Stem Cell Centre

Collection, Processing, Storage and Distribution of Human Umbilical Cord Tissue and Placenta for Medical Research

I. INVITATION AND PURPOSE

You are invited to donate your baby's placenta and/or cord tissue for medical research. You are being invited because you have already agreed to donate your baby's cord blood to Celebration Stem Cell Centre (hereafter CSCC) for patients in need of a transplant. The use of Mesenchymal stem cells found in umbilical cord tissue and use of the placental matrix is a recent advancement in medical research. Mesenchymal stem cells have the capability to become nerve, muscle, cartilage and bone cells. The umbilical cord contains three blood vessels which are surrounded by Wharton's jelly, a gelatin-like substance that contains mesenchymal stem cells. These cells are currently being used to treat sports injuries and diabetic ulcerations of the skin. Recently, these cells have been used to treat serious conditions such as Multiple Sclerosis and Parkinson's disease. The use of placental matrix has also showed positive results in regenerative medicine. Your baby's cord tissue and placenta are normally discarded as medical waste after your baby is delivered.

CSCC gives investigators cord tissue and placental tissue to use in medical research. Although the exact studies for which tissue units may be used is not known at this time, the following are types of uses in which the tissue may be utilized:

- To examine the safety and efficacy of unrelated cord tissue stem cell transplants.
- To evaluate different methods of processing the tissue to produce optimal numbers of stem cells available for stem cell transplants.
- To study other factors that contribute to transplant recipient success (such as growth factors and anti-inflammatory mediators)
- To examine whether the way the cord tissue and placenta is collected, processed, and stored has any effects on survival and complications in transplant recipients.

In addition, researchers may conduct research studies with cord and placental tissue that have had all identifiers removed. In these studies, there will be no way for the tissue to be linked to you or your baby. CSCC may allow researchers to use the anonymous cord and placental tissue for many other kinds of studies. These studies are not limited to the types of studies listed above, or related to transplantation in general. CSCC may charge a fee for service basis for development of diagnostic tests or other products or other research.

II. PROCEDURES

If you agree to donate your baby's cord or placental tissue for medical research, nothing additional is required from you. Your baby's cord or placental tissue may also be frozen and stored indefinitely for possible use in future research studies. Cells from the cord tissue may be grown in the lab so there are more of them that can be used in research studies. DNA, the genetic portion of the cells, may be used in some of the studies.

III. POSSIBLE RISKS AND BENEFITS

There are no physical risks to your or baby by donating the cord or placental tissue to be used in medical research.

There is a small risk that an unauthorized person could find out which cord or placental tissue is your baby's. CSCC has procedures in place to keep your data private. No identifiable information about you will be given to the researchers, nor will it be published or presented at scientific meetings.

You or your baby will not be helped by donating your baby's tissue for medical research. However, this research may help future patients who need a transplant or other medical treatment.

IV. CONFIDENTIALITY

CSCC will not intentionally tell anyone that you donated your baby's cord or placental tissue for medical research. CSCC will make sure no one outside CSCC will know which tissue is yours. Your name or your baby's name or other identifying information will not appear on the umbilical cord or placental tissue unit or on any study records maintained outside of CSCC. Authorized staff from CSCC will have access to your and your baby's personal information. CSCC will not disclose your or your baby's participation by any means of communication to any person or organization, except by your written request or permission, or unless required by federal, state, or local laws, or regulatory agencies. You will not know who receives the umbilical cord tissue stem cells and the recipient of the umbilical cord or placental tissue will not be given the identity of you or your baby.

V. REIMBURSEMENT AND COSTS

You will not be paid for donating your baby's cord or placental tissue for medical research. It will not cost you anything to donate your baby's cord or placental tissue for medical research.

VI. VOLUNTARY PARTICIPATION IN AND WITHDRAWAL

It is up to you if you want to donate your baby's cord or placental tissue for medical research.

If you decide to donate your baby's cord or placental tissue for medical research you may change your mind at any time in the future. If you decide you don't want your baby's cord or placental tissue used for medical research, your baby's cord or placental tissue will be destroyed. This will not affect your relationship with CSCC. Contact CSCC at (480) 722-9963 if you'd like to withdraw.

VII. ALTERNATIVE TO PARTICIPATION

You may choose not to donate your baby's cord or placental tissue for medical research. If you choose not to you can also choose to store the cord tissue privately at your own expense (placental tissue will not be stored) or have the cord tissue destroyed.

VIII. QUESTIONS OR CONCERNS

If you have questions, about donating your baby's cord tissue for medical research contact Lorri Lawson at (480) 722-9963.

You will be given a copy of this consent form for your records.

IX. SUBJECT'S STATEMENT OF CONSENT

I have read this consent form and I have been given the opportunity to ask questions. I voluntarily agree to donate my baby's cord or placental tissue for medical research studies as defined in this consent form.

_____ _____

Subject Signature *Date*

_____

Print Name of Subject

Person Authorized Pursuant to Law to Consent to Health Care for the Expectant Mother (if Expectant Mother is a minor):

_____ _____

Print Name of Authorized Person *Signature of Authorized Person*

_____ _____

Date *Relationship to Expectant Mother*

Based on the information that has been provided to me, I elect the following for my Cord Tissue and Placenta (please select one):

□ I elect to have my Cord Tissue and Placenta processed and cryopreserved at Celebration Stem Cell Centre

□ I elect to have my Cord Tissue and Placenta donated to Celebration Stem Cell Centre for medical research.

Use of an Interpreter: Complete if the subject is not fluent in English and an interpreter was used to obtain consent.

Print name of interpreter: _____ Date: _____

Signature of interpreter: _____ Date: _____

An oral translation of this document was administered to the subject in _____ (state language) by an individual proficient in English and _____ (state language). See the attached short form addendum for documentation.