

**FORM 3: APPLICATION FOR EXTENSION OF FROZEN EMBRYO STORAGE PERIOD FOR USE IN IVF PROCEDURE**

**Direction 6.10**

**INSTRUCTIONS**

- Application can only be made by eligible participants ie those for whom the embryo was developed or, if consent for receipt after donation has been completed, the recipient(s).
- Both Part A and Part B of the application should be completed.
- Applications should be received by the Executive Officer of the Reproductive Technology Council at least one month prior to the meeting of the council preceding expiry of the current storage period.
- Approval for extension of storage cannot be granted if the storage period has already expired. Embryos are required to be removed from storage if the storage period expires and no extension has been granted.
- Please mark your envelope 'Confidential' and return this application to: the Executive Officer, Reproductive Technology Council, Health Dept of WA, 189 Royal Street, East Perth WA 6004 email: [embryo.storage@health.wa.gov.au](mailto:embryo.storage@health.wa.gov.au)

**PART A**

*Clinic to complete:*

1. Have these embryos been granted a previous extension?    yes     no

**2. Storage details:**

Date of expiry of current storage period                   10 years from date embryos placed in storage in WA, or date of expiry of any later current extension

Date of Completion by Clinic                   Licensee number

**3. Treatment cycle details:**

Participant ID Code    Female            Partner (if any)

Treatment unit ID   

Treatment cycle codes:    Cycle ID              Fertilisation    F

Date cycle commenced             

Date of embryo storage in WA             

Female DOB:                   Partner DOB:             

Number of embryos affected by this   

Also indicate Participant ID codes of donor/s here of applicable:

Female            Partner (if any)

**Health Department use only:**    Application Number        -        Code   

Date of Expiry of Extended Storage Period             

Chairperson, RTC \_\_\_\_\_

## PART B

*Eligible Participant(s) to complete:*

Date of Application

Eligible Participant	Female	Partner (if any)
	Family name _____	Family name _____
	Given name _____	Given name _____

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode:  Phone Number: \_\_\_\_\_

You will be contacted by mail for notification of the outcome of your application or should we require further information in order to process your application. Your phone number will only be used to contact you if further information is required within a short time frame, we do not anticipate this happening in the majority of cases. Should we attempt to contact you discretion will be used and we will only speak to the participant or their partner.

Please indicate if there are any restrictions to the way in which you would like us to contact you.

\_\_\_\_\_

1. Who is applying?:

(a)  Both members of the eligible couple.

(b)  One member only of the eligible couple.

(c)  Eligible single person.

2. Are you seeking an extension with the intention of:

(a)  Using the embryos for your own treatment at a later time.

(b)  Donating the embryos to an eligible recipient/s.

(c)  Other

3. Briefly explain your reasons for seeking an extension:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. When do you plan to use or dispose of your embryos?

\_\_\_\_\_

Signature of applicant(s) \_\_\_\_\_  
\_\_\_\_\_