Attachment 1

Medical Certificate for Assisted Reproduction

<Use for issuance of kinsfolk relation record certificate in accordance with Article 3 of the Regulations from the local household administration only. For donated oocyte or sperm, applicant shall be the recipient husband or wife respectively.>

Name of the Applicant		Sex/Gender	□Male □Female
Age		Date of Birth: YY MM DD	
National ID card No.			
Foreigner's ID No.			
Foreigner's passport No.			
Registered Address	County Township Ward Road City District Ward Neighborhood Street Section Lane Alley Number Floor		
Residence Address	County Township Ward Road City District Ward Neighborhood Street Section Lane Alley Number Floor		
Medical Record No.		Tel. No.	
Name of Spouse		Sex/Gender	□Male □Female
Age		Date of Birth: YY MM DD	
National ID card No.			
Foreigner's ID No.			
Foreigner's Passport No.			
Registered Address	County Township Ward Road City District Ward Neighborhood Street Section Lane Alley Number Floor		
Residence Address	County Township Ward Road City District Ward Neighborhood Street Section Lane Alley Number Floor		
Medical Record No.		Tel. No.	
Note	Hereby I certify that the applicant is really in need of undertaking assisted reproduction. Please agree to his/ her application for kinsfolk relation record certificate in accordance with Regulations for Verification on Kinship between the Sperm/Oocyte Donor and the Recipient prescribed pursuant to Article 15, Paragraph 2 of the Assisted Reproduction Act. The kinship shall include the applicant's lineal blood relatives and the collateral relatives by blood within the fourth degree of relationship, as well as lineal relatives by blood and by marriage of the applicant's spouse.		

Name of Physician:_____ Signature:_____
Physician Certificate No.: _____
Title of the Institution:_____
Medical Practice License No.:_____
Address of the Institution:_____
Telephone of the Institution:_____
Date:_____YY____MM____DD