Attached Form 2

Reproductive Cell Donor Health Examination and Assessment Notification Form

I. Institution name: _____ Institution code: ☐☐☐☐☐

II. Donor data:

1. Name: _____ 2. Date of birth: _____(y) _____(m) _____(d)
3. National ID card number: ☐☐☐☐☐☐☐☐☐☐
4. Alien resident certificate ID number (Note): ☐☐☐☐☐☐☐☐☐☐
5. Foreigner passport number: ☐☐☐☐☐☐☐☐☐
6. Case history number: _____

III. To be filled out by donor:

1. Skin color: ☐1.Yellow ☐2.White ☐3.Black ☐4.Brown ☐9. Other _____
2. Hair color: ☐1. Black ☐2. Brown ☐3.Blond ☐4. Red ☐9. Other _____
3. Are you an intravenous drug user? ☐0. No ☐1.Yes
4. Are any of your sex partners members of an AIDS risk group? ☐0. No ☐1.Yes ☐9. Don't know
5. Have you had more than one sex partner during the last six months? ☐0. No ☐1.Yes
6. Have you experienced difficult urination during the last six months? ☐0. No ☐1.Yes
7. Have you had urethral secretions during the last six months? ☐0. No ☐1.Yes
8. Have you had any ulcers of the reproductive organs during the last six months? ☐0. No ☐1.Yes

*9. Do you have a history of chromosomal abnormalities ☐0.No ☐1.Yes

*10. Do you have a history of hemophilia ☐0.No ☐1.Yes

*11. Epilepsy ☐0.No ☐1.Yes

12. Dwarfism ☐0.No ☐1.Yes
13. Congenital deafness ☐0.No ☐1.Yes
14. Marfan's syndrome ☐0.No ☐1.Yes
15. Family history of color blindness ☐0.No ☐1.Yes
16. Other hereditary diseases ☐0.No ☐1.Yes
17. Have you or any family member to the fourth degree of kinship obtained a disability handbook?

    ☐0.No ☐1.Yes: Relationship: _____ Type of disability: _____

    Disability level: _____ Reason for occurrence: _____

18. Do you or any family member to the fourth degree of kinship suffer from a

hereditary disease?

☐0.No ☐1.Yes: Relationship: _____ Name of disease: _____

19. Have you obtained a major sickness and injury card?

☐0.No ☐1.Yes Name of disease: _____

I hereby certify that the information provided above is truthful and correct. I am willing to bear all legal responsibility for any falsehood or fabrication.

Signature and seal of donor:_____Date filled out:___(y)___(m)___(d)

IV. Health assessment items [to be filled out by the institution]

General physiological examination: ☐No ☐Yes	Other major diseases:
Mental illness: ☐No ☐Yes	Diabetes ☐No ☐Yes Test items: _____
Infectious disease:	Thalassemia ☐No ☐Yes Test items: _____
* AIDS ☐No ☐Yes Test items: _____	Chlamydia ☐No ☐Yes Test items: _____
* Syphilis ☐No ☐Yes Test items: _____	Cervical Smear test results: _____
* Gonorrhea ☐No ☐Yes Test items: _____	Other (please state) _____
Hepatitis B surface antigen ☐No ☐Yes Test items: _____	ABO blood type Results: _____
Hepatitis C ☐No ☐Yes Test items: _____	RH(+) or (-) Results: _____

V. Health examination and assessment results: ☐ 1. Suitable for donation ☐2. Not suitable for donation, reason: _____

I hereby certify that I have discussed the foregoing questions with the donor and have explained to him/her related rights and responsibilities; the donor's understanding and written consent have been obtained.

Physician: _____

Assessment completion date: (y) (m) (d)

Date received: ____(y)___(m)___(d) Accepted by:_____

Note: Foreigners who do not have a national ID card shall fill out items 4 and 5; foreigners with no alien resident certificate ID may submit equivalent identification documents from their country of origin, and fill in the serial number on those documents.

Instruction:

1. Disease items marked with an "*" absolutely rule out donation.
2. This form shall be sent to the competent authority by registered mail within 14 days from the assessment completion date (based on postmark date); the Institution shall preserve the second leaf.