CENTRAL ASSISTED REPRODUCTIVE TECHNOLOGY (ART) REGISTER

(*Assisted Reproductive Technology Act 2007,* section 33)

ART PROVIDER DETAILS

Registered ART provider: _____

Name of the premises and address: _____

_____

_____

_____

CHILD DETAILS (Details of the child born as a result of ART treatment using the donated gamete)

Surname: _____

Given name/s: _____

Date of birth: _____/_____/_____ Gender: Male ☐ Female ☐

Mother's Surname: _____

Mother's Given name/s: _____
(The woman who gave birth to the offspring)

DONOR DETAILS (Details of the person who donated the gamete)

Surname: _____

Given name/s: _____

Date and place of birth: _____/_____/_____ _____
(including suburb, town or city of birth and the country of birth)

Gender: Male ☐ Female ☐

Residential address: _____

_____

_____

_____

Date donor supplied gametes in relation to this birth: ____/____/_____

Date of donor consent relating to this donation: _____/_____/_____

Gamete provider's consent attached: Yes ☐ No ☐ (A copy of the gamete provider's consent must be attached)

Donor code: _____

Ethnicity and physical characteristics (including but not limited to hair colour, eye colour, skin colour):

Medical history or genetic test results of the donor or the donor's family that are relevant to the future health of:

a) a person undergoing ART treatment involving the use of the donated gamete, or
b) any offspring born as a result of that treatment, or
c) any descendants of any such offspring.

Name of each ART provider who has previously obtained a donated gamete from the donor and the date on which the gamete was obtained:

The sex (gender) and year of birth of all offspring born of the donor whether conceived by ART or not. Please also indicate the number of families to whom this donor has donated:

Section 27, Maximum number of families: Does the mother of this child come within the exemption under section 27(1A)? If yes please provide the name of her spouse:

Details of the person completing the form:

_____ _____

(Print Name) (Signature)

_____ _____

(Position) (Date)

Please complete and post to: Regulation and Compliance Unit
Legal and Regulatory Services Branch
NSW Ministry of Health
Locked Mail Bag 961
NORTH SYDNEY NSW 2060

Contact Details: Email: artphcu@doh.health.nsw.gov.au
Telephone: (02) 9424 5955