



REGISTRATION AND PAYMENT FORM

PLEASE PRINT CLEARLY (Black ink)	MOTHER	FATHER/ PARTNER
FIRST NAME		
LAST NAME		
DATE OF BIRTH (Month/ Day/ Year)		
WORK PHONE		
EMAIL		

HOME ADDRESS			
CITY, PROVINCE/ STATE			
POSTAL CODE/ ZIP/ COUNTRY			
HOME PHONE & EMAIL			
NAME/ ADDRESS/ PHONE of a friend/ family whom we should contact in case you move.			
DUE DATE	Month:	Day:	Year: TWINS _____
DELIVERY HOSPITAL NAME	CITY		
PRENATAL Dr/ MIDWIFE			

CREDIT CARD INFORMATION

The following credit card will be used to pay fees related to the collection kit, cord blood processing, medical testing, first year annual/ 18 year storage fees as per Exhibit A (enclosed), and any shipping fees as applicable.

TYPE OF CARD: MASTERCARD ____; VISA ____; AMEX ____

CREDIT CARD NUMBER: _____ EXP. DATE: ____/____

NAME OF CARD HOLDER: PLEASE PRINT _____

AUTHORIZED SIGNATURE: _____

I WOULD LIKE TO RECEIVE MY INVOICES/ STATEMENTS IN English **OR** French

STORAGE FEE PAYMENT: Parents may choose to pay storage fees annually **OR** 18 years in advance.

- 18 Year Storage Payment: Please use this credit card for the full 18-year advance storage fee payment.
- OR
- Annual Storage Payments: Please invoice me annually by mail.
- Please automatically charge this credit card annually on the 1st day of the month of my child's birth.

Parents: Please contact our accounts department to make updates to your accounting and/or contact information:

Email: accounts@cellsforlife.com Phone: 905 472 0060 Ext 25 Toll-free: 1 877 235 1997 Ext 25

Privacy Policy is available upon request or online at www.cellsforlife.com/privacy.htm

FOR OFFICE USE ONLY

Single Twins CFL VAR 1st time Repeat _____ Prom. Medicaid 3x Install.

Registration	Kit	Shipping	CFL Pickup	Processing	Blood testing	Storage	Other



SHIPPING REQUEST FORM

This form is for those clients who wish to have a cord blood collection kit shipped to them from Cells for Life prior to the birth of their baby.

- STEP 1:** Complete this *Shipping Request Form* and the *Registration and Payment Form*. Fax both to our Shipping Department at 905 472 2185.
- STEP 2:** A Shipping Coordinator will call you to arrange your delivery.
- STEP 3:** The kit will be shipped to the location indicated below. Please review the contents of the kit upon receipt and complete all forms prior to your baby's due date. All forms in the kit must be completed and returned with the cord blood to our laboratory. We highly recommend that this is NOT done at the time of birth ---- you will be busy and rather pre-occupied at that time!

SHIPPING DEPARTMENT CONTACT INFORMATION:

Ph: 905-472-0060 Ext 29 or Toll-free: 1-877-235-1997 Ext 29
Cells for Life, 377 Church Street, Suite 201, Markham, Ontario Canada L6B 1A1

SHIPPING INFORMATION

You may decide where you would like the kit to be delivered --- Work, Home or to a Friend.

Please note that all kits must be shipped to a location where:

- > Someone will be present to accept the shipment and the kit can be kept at room temperature
- > Courier Delivery times to your location: Tuesdays – Fridays between 9:00 am and 5:00 pm

Name	
C/o Company Name (if appl.)	
Shipping Address	
City, Province/ State	
Postal Code/ ZIP	
Country	
Phone # to organize shipping	
Phone # of delivery location Contact person's name	

SPECIAL INSTRUCTIONS:

NOTE: Clients are responsible for payment of all shipping fees.

Authorized Signature: _____