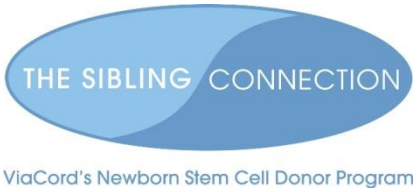
ViaCord Sibling Connection Program Service Agreement



CONGRATULATIONS

On choosing to preserve your baby's

Newborn Stem Cells with ViaCord's Sibling Connection Program!

To complete the process **please PRINT, SIGN, and DATE the signature page on page 11 and Return all pages of this Service Agreement as soon as possible**. Please also include a signed and dated copy of the complete **Health History Questionnaire.**

You may return the documents by fax, mail, or email.

Option 1: FAX your completed forms to: 781-663-8099 (using the Fax Cover sheet provided in this packet)

Option 2: MAIL your completed forms to:

ViaCord
Attn: Sibling Connection
940 Winter St.
Waltham, MA 02451

Option 3: EMAIL your completed forms to: siblingconnection@viacord.com

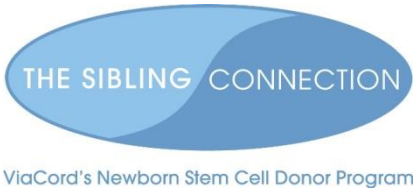
ViaCord Sibling Connection Program Service Agreement

FAX COVER SHEET

To:	**ViaCord, Attn: Sibling Connection**
Phone:	**1-866-861-8435** or **1-800-998-4226**
Fax:	**781-663-8099**
From:	
Sender's Phone Number:	
Sender's Fax Number:	
Date:	
Pages Including cover page:	
Comments:	

This facsimile contains privileged and confidential information intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you have received this facsimile in error, please immediately notify the transmitting office by telephone at ***(866) 861-8435 or (800) 998-4226*** *and return the original facsimile to the transmitting office* **ViaCord, Attn: Sibling Connection, 940 Winter St., , Waltham, MA 02451** *via US Postal Service. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Any further disclosure of this information without the prior written consent of the person to whom it pertains may be prohibited.*

ViaCord Sibling Connection Program Service Agreement



Introduction

This Service Agreement is between ViaCord, LLC and you. ViaCord's service covers cord blood stem cell collection, processing, and storage.

This agreement covers the collection materials and the testing, processing, cryopreservation, storage, and potential release of the cord blood stem cells from the umbilical cord after the delivery of your child for the potential benefit of the child's sibling.

Key Terms

The following terms will be used throughout this agreement:

- **Agreement** refers to this ViaCord Service Agreement.
- **ViaCord** refers to ViaCord, LLC.
- **Parent(s)** refers to you, the person(s) who is a party to this agreement.
- **Services** refers to the testing, processing, cryopreservation, and storage of the Newborn Stem Cells.
- **Newborn Stem Cells** refer to the cord blood stem cells that are found in the umbilical cord of the child who is being delivered.
- **Child** refers to the baby being delivered and whose Newborn Stem Cells are the subject of this Agreement.
- **Parties** refers to you, the Parent(s), and Viacord.
- **VPL** refers to the ViaCord Processing Lab.
- **Collection Kit** refers to the container that holds the materials necessary for the collection and transportation of the Newborn Stem Cells.
- **Sibling** refers to a child who shares two biological parents with the Child, e.g., full sister or brother.
- **Sibling Connection Program** refers to ViaCord's directed donation program for families regardless of their financial situation.
- **Term** refers to the time starting with the date of the Child's birth and ending on the Child's fifth birth day.

Parent(s) Responsibilities

I acknowledge and agree that I am responsible for the following:

Before the Big Day

- Confirm that the Sibling's condition qualifies as one of the eligible diagnoses. The list of eligible diagnoses is available on the ViaCord website at http://www.viacord.com/about/giving-back/sibling-connection-program/.
- Authorize the Sibling's treating physician to release medical information relevant to qualifying the Child for enrollment in the Sibling Connection Program on the Medical Referral Form.
- Return the Medical Referral Form completed by Sibling's treating physician with the qualifying condition.
- Read, complete, and sign this Agreement and return it as soon as possible to **ViaCord, Attn: Customer Service, 940 Winter St., , Waltham, MA 02451 or Fax to 781-663-8099, or email to csr@viacord.com**.
- Read, complete, and sign the Health History Questionnaire and return it to ViaCord prior to delivery. The Health History Questionnaire is an important document that ViaCord is required by law to have

on file for the potential release of the Newborn Stem Cells in the event they are needed for treatment.

- Check the expiration date on the Collection Kit. If the Collection Kit has expired or is likely to expire prior to your delivery date, call ViaCord at **800-998-4226** to request a new Collection Kit and for instructions on returning the expired kit.
- Keep the Collection Kit in a cool, dry place along with your hospital bag.

Before Delivery

- Inform the physician/midwife of my plan to collect the Newborn Stem Cells for the benefit of the Child's Sibling.
- Bring the Collection Kit to the hospital on the day of delivery.
- Hand the Collection Kit to my doctor/midwife.
- Inform my Labor and Delivery staff that cord blood will need to be collected.
- Notify the Labor and Delivery staff that a maternal blood sample will need to be drawn and included in the Collection Kit.
- If my Labor and Delivery staff changes, I will inform the new staff of the Newborn Stem Cell collection.

After Delivery

- After the Newborn Stem Cells and maternal blood sample collection have been completed, follow the instructions within the Collection Kit to inspect the cord blood bag and 3 vials of maternal blood for any leaks or other defects.
- Contact ViaCord after the collection of the Newborn Stem Cells, within two (2) hours of collection so that ViaCord may arrange for transportation of the Collection Kit VPL. This will enable optimal cell recovery and viability.
- During my call with ViaCord Customer Service, which will last approximately 5 to 10 minutes, I agree to review the contents of the Collection Kit before sealing and answer any follow-up questions regarding the Health History Questionnaire.
- Keep the Collection Kit at room temperature and nearby until the medical courier arrives.
- Notify ViaCord of any changes to my contact or payment information while this Agreement is in effect.
- Update ViaCord of any relevant health information regarding the Child or the Sibling.

ViaCord's Responsibilities

ViaCord is responsible for the following:

- Review the Sibling's Medical Referral Form to determine the Child's eligibility in the Sibling Connection Program.
- Upon acceptance in the Sibling Connection Program, provide you with a Collection Kit to bring with you on the day of delivery, which includes instructional materials for the doctor/midwife who will perform the Newborn Stem Cell collection.
- Arrange for a medical courier to transport the Collection Kit to VPL upon receipt of your call following the delivery of your Child, and the collection of the Newborn Stem Cells and the maternal blood samples.

  Transportation of the Collection Kit

  - No courier service can guarantee that the Collection Kit will reach VPL without delay, loss or damage in transit, however, the medical courier ViaCord contracts with is a transportation service provider for industries that require immediate turn-around time and specialized handling of organs for transplant and blood products.
  - The transportation service provider utilizes local couriers and the following methods of transportation to get your Collection Kit to VPL as safely and as quickly as possible: private jet fleets, ground transportation, and commercial air carriers.

  - Neither the courier service nor ViaCord guarantees that the Collection Kit will reach VPL without delay, loss or damage in transit. **In addition, ViaCord does not accept responsibility for failure to bank the Newborn Stem Cells due to any transportation problems.**
  - ViaCord does not insure the Newborn Stem Cells against risk of loss or damage while they are in transit to VPL or at any time thereafter. If you wish to obtain such insurance you must procure it separately, at your own financial expense.
- Test the maternal blood samples for certain infectious diseases, including but not limited to human immunodeficiency virus (HIV) type 1 and 2, hepatitis B virus, hepatitis C viruses, human T-lymphotrophic virus (HTLV) type I and II, cytomegalovirus (CMV), syphilis, and any other relevant infectious disease, as required by law.
- Lab specialists at VPL will test a small sample of my Child's Newborn Stem Cells to characterize the stem cells, such as: determine how many total nucleated cells (TNCs) were collected; perform cell viability, CD34+ count, and microbial cultures to test for bacterial and fungal elements to determine the quality of the Newborn Stem Cells, as required by law.
- Process, test, cryopreserve, and store the Newborn Stem Cells in a secure area, as required by law.
- Once the Newborn Stem Cells have been successfully processed and stored, ViaCord will send you a Certificate of Preservation and a Results Letter that includes the TNC count and volume collected for the cord blood stem cells.
- Store the Newborn Stem Cells for the Term of five years, starting on the birth of the Child at no cost to the Parent(s).

How ViaCord Communicates with You

ViaCord prides itself on building strong relationships with its customers.

In order to maintain this relationship, ViaCord may communicate with you regarding your Services, as well as updates regarding new research and treatments. ViaCord utilizes several forms of communication, such as:

Phone
Postal Mail
Fax
Email
Text Messages; standard text messaging rates may apply.

In order for ViaCord to communicate most effectively, please make sure your information is up to date. If there is a change in your information, please contact Customer Service at **(866) 861-8435 or 800-998-4226.**

Informed Consent of Parent(s)

PLEASE NOTE: Parents under the age of 21 must complete and return an additional form.

I elect to privately bank my Child's Newborn Stem Cells with ViaCord; I have read and understand my responsibilities and ViaCord's Responsibilities listed above and I hereby authorize my doctor/midwife to collect, and ViaCord to process and store my Child's Newborn Stem Cells after delivery. I am at least 21 years of age and I am able to lawfully enter into a contract with ViaCord. Below is important information I need to review and understand about the risks and benefits involved in the process of collecting, processing, and storing the Newborn Stem Cells.

ViaCord Sibling Connection Program Service Agreement

I understand that I have the following options regarding my Child's Newborn Stem Cells:

1) Discard the Newborn Stem Cells as medical waste.
2) Donate my Child's cord blood to a public bank, if available.
3) Privately bank the Newborn Stem Cells.

I understand that there are benefits and risks associated with the collection of my Child's Newborn Stem Cells. I understand that the Newborn Stem Cells are being stored for potential therapeutic use by the Child's Sibling. I understand that Cord Blood Cell Banking does not guarantee that the cord blood stem cells will be suitable for all treatments or that treatment will work and only a doctor can determine when it can be used.

- **Collection Process for Cord Blood Banking**
  The collection process for Cord Blood Banking is easy and painless and should not interfere with the delivery or the subsequent care of my Child. This procedure is painless and noninvasive for the Child. After the Child is delivered, but before the placenta is delivered, the doctor/midwife will clean a four- to eight- inch area of umbilical cord with antiseptic solution and will insert the blood bag needle into the umbilical cord vein. The blood flows into the bag by gravity until it stops, after which the collection is complete. The blood bag is clamped, knotted, sealed, and labeled. The collection typically takes two to four minutes.

- **Preparing Your Child's Newborn Stem Cells for Storage**
  At VPL, lab specialists process the cord blood in preparation for long-term storage.
  When the processing of the Newborn Stem Cells is complete, lab specialists transfer the Newborn Stem Cells to transplant-ready cryobags for cryopreservation.
  The cryobags are then frozen and stored at or below -150 degrees Celsius in a storage freezer that is protected and housed in VPL's severe weather resistant storage vault where the storage freezer temperature is continuously monitored to detect even the smallest change.

I understand that, although infrequent, complications may occur at birth and it may not be possible for the performing physician/midwife to collect my Child's Newborn Stem Cells. In addition, Newborn Stem Cells may become contaminated during the collection process. My health and the health of my Child are the first priorities of the physician/midwife. If any complications occur during birth, the performing physician/midwife may elect not to collect the Newborn Stem Cells.

- **Suitability of Newborn Stem Cells for Storage**

  Upon arrival at VPL, samples of all Newborn Stem Cells will be tested for microbial contamination that may affect a physician's decision to use the Newborn Stem Cells for transplant or other forms of treatment. ViaCord will keep additional samples of the Newborn Stem Cells in storage for possible future testing. I acknowledge and agree that since a physician may wish to have the option to try and use Newborn Stem Cells, regardless of contamination status, ViaCord will store all Newborn Stem Cells, regardless of the presence of microbial organisms, without notice to the Parent(s) unless the health of the mother and/or Child is potentially at risk and/or ViaCord's Medical Director determines notification is appropriate.

  For parents who have purchased ViaCord's Newborn DNA Guardian ℠ product, ViaCord will store an additional dried blood spot card for possible future genetic testing.

  In addition to testing the Newborn Stem Cell samples, the maternal blood samples will also be tested for HIV or certain other communicable diseases, as required by federal law. I further acknowledge and agree that since a physician may wish to have the option to try and use Newborn Stem Cells regardless of the presence of a communicable disease in the maternal blood sample, ViaCord will store all Newborn Stem Cells, except in situations where the maternal blood sample is confirmed positive for HIV, by testing or if

there is an affirmative response on the Health History Questionnaire regardless of the presence of any other such communicable diseases in the maternal blood sample, without notice to the Parent(s).

Since it is anticipated that the Newborn Stem Cells will be used in transplant, Parent(s) acknowledge and agree that ViaCord is allowed to disclose test results and other information related to the maternal blood and/or Newborn Stem Cells to healthcare providers involved in the care of the Sibling who is the potential newborn stem cell transplant recipient. Parent(s) understand that ViaCord agrees to protect identifiable health information by using and disclosing it only for the purposes authorized in this Agreement or as required by law. This limitation will survive the cancellation or termination of the Agreement.

The storage of the Newborn Stem Cells does not guarantee the suitability of the Newborn Stem Cells for any or all types of future use. Release of the Newborn Stem Cells may be prohibited by federal and/or state law due to contamination status, the presence of communicable disease in the maternal blood sample or any other reason. In the event Newborn Stem Cells are available for use, only ViaCord's Medical Director and a qualified physician can decide whether the use of the Newborn Stem Cells outweighs any potential medical risk.

> *[**Note: New York Residents Only**. It is a requirement of the New York State Department of Health that the Newborn Stem Cells are frozen within forty-eight (48) hours of collection. If the Newborn Stem Cells are not frozen within forty-eight hours, ViaCord's Medical Director will need to specifically authorize the storage of the Newborn Stem Cells.]*

I understand that ViaCord may also choose not to process and/or store the Newborn Stem Cells for any of the following reasons, including, but not limited to: low volume or low weight of Newborn Stem Cells, improper collection technique, improper or untimely handling and shipment of the Newborn Stem Cells, or my failure to call ViaCord for courier service **within the two (2) hour period after my delivery**.

If ViaCord decides not to proceed with the storage of the Newborn Stem Cells for any reason, I will be notified in a timely manner.

I understand and agree that the test results for the Newborn Stem Cells may be used for quality control purposes and for analyses and in publications, provided that they are aggregated with other data and do not contain any identifying information.

Decision-Making Authority for the Newborn Stem Cells

Ownership of the Newborn Stem Cells is a legal matter that may be determined in accordance with the laws of various jurisdictions. While ViaCord acts only in the capacity of a service provider and does not undertake to resolve legal ownership issues, ViaCord's approach is to accept the Newborn Stem Cells from me as the legal guardian(s) of my Child. Absent termination of this Agreement, ViaCord will assert no rights in connection with disposition of the Newborn Stem Cells.

As the legal guardian(s), I am responsible for acting on behalf of my Child until s/he reaches the age of majority, which may vary depending upon the state of residency and other then-current laws and regulations. As a service provider of banking services, I understand that ViaCord will act in the following manner, during any period that banking services are provided:

> ViaCord shall be entitled to rely on my instructions regarding the disposition of the Newborn Stem Cells, change in contact information, and/or any other requirement for Services under this Agreement.

In the event that I wish to assign the rights and obligations under this Agreement to a third party, including my Child if the Child has reached majority for purpose of contract formation, this new party must sign a new Service Agreement with Viacord to confirm their understanding and agreement of the terms and conditions of the Services.

I understand that once I assign the rights and obligations under this Agreement to a third party, this Agreement will become null and void.

After the Child reaches majority, I may continue to pay storage fees for the benefit of my Child, absent any contrary written instruction by my Child.

When my Child reaches the age of majority, my Child may assert ownership claims to the Newborn Stem Cells but must sign the new Service Agreement, as noted above.

In the event of a dispute between me and any third party, including my Child, over ownership of the Newborn Stem Cells, ViaCord will continue to provide banking services, provided that all payments have been and continue to be made, until such time as ViaCord is presented with a final court order that mandates a change in ownership. At such time, the new owner will be provided an opportunity to sign a new Service Agreement or otherwise provide ViaCord with instructions to discontinue banking services.

Absent either contrary instructions from me or a final court order, as long as banking service fees continue to be paid, Newborn Stem Cells will be subject to the Service Agreement.

I understand that I am allowed to request the Newborn Stem Cells be transferred to another cord blood bank provided that the other cord blood bank is approved by the FDA to receive the Newborn Stem Cells and all state and federal regulations are followed. I understand that I am responsible for all shipment expenses and an administrative fee if I transfer the Newborn Stem Cells to another qualified cord blood bank. I understand that in order to transfer the Newborn Stem Cells I will need to sign ViaCord's Transfer Agreement.

I understand that I have the right to have my questions answered and to receive a copy of this consent. If I have any questions regarding this Agreement, I can contact ViaCord Customer Service at (866) 861-8435 or 800-998-4226.

I understand that I have the right to withdraw my consent to collect, process, and store my Child's Newborn Stem Cells prior to the collection, processing, and/or storage of the Newborn Stem Cells by sending a signed letter of revocation by mail, fax, or email to **ViaCord, Attn: Customer Service**, **940 Winter St. , Waltham, MA 02451** Fax: **781-663-8099**, or email: **csr@viacord.com**. I understand that if I revoke my consent I will no longer be eligible for ViaCord's Sibling Connection Program.

Request for Use of Newborn Stem Cells for Treatment or Clinical Trial

ViaCord is required to have an executed Agreement and Maternal Health History Questionnaire on file in order to release Newborn Stem Cells for use in treatment. In the event that the Newborn Stem Cells are requested for transplant, ViaCord requires authorization and an Informed Consent by at least one Parent to release the Newborn Stem Cells, as well as a written request from a physician qualified to perform a stem cell transplant. The Newborn Stem Cells may only be used for the transplant of the Child or a first or second degree blood relative, such as the Sibling, with some exceptions. ViaCord's Medical Director, along with the treating physician, are responsible for donor eligibility determination and acceptability of the Newborn Stem Cells in the requested transplant prior to release of the unit, except in situations of Urgent Medical Need, in which case, the donor eligibility determination may be made after the release of the Newborn Stem Cells. ViaCord will only release the Newborn Stem Cells in accordance with federal and state regulations. If the Newborn Stem Cells are eligible for transplant, ViaCord will ship the Newborn Stem Cells to the identified

facility. If the Newborn Stem Cells are released for the treatment of the Sibling, ViaCord will charge the transplant facility for fees related to the release of the Newborn Stem Cells.

Payment of the Services

Parent(s) are not responsible for any fees related to the processing, collection, storage, or release of the Newborn Stem Cells during the Term of the Sibling Connection Program.

- I understand that if I wish to continue storage of the Newborn Stem Cells beyond the Term of the Sibling Connection Program, I am responsible for the payment of the storage fees. ViaCord guarantees that the storage fee(s) for the Services will not change for twenty-five (25) years from the expiration of the Term.
- I understand that ViaCord is not responsible for reimbursing me for any fees including fees that my physician, midwife, or other medical professional may charge for the collection of the Newborn Stem Cells.
- I understand that ViaCord may reimburse a physician for the collection of the Newborn Stem Cells and I may ask my physician or healthcare provider whether ViaCord is reimbursing them for the collection of my Child's Newborn Stem Cells.
- I acknowledge and agree that I am ultimately responsible for the payment of the storage fees for the Newborn Stem Cells beyond the Term of Sibling Connection Program unless I decide to terminate the Agreement prior to the Child's fifth (5^{th}) birth date.

ViaCord agrees to accept payments by third parties on my behalf for the continued storage of the Newborn Stem Cells beyond the Term of the Sibling Connection Program. The third party payer does not have any rights in the Newborn Stem Cells and ViaCord will not take instructions regarding the Newborn Stem Cells from any third party, with the exception of third parties who have assumed the rights and obligations under a proper assignment of this Agreement.

Termination of this Agreement

This Agreement may be cancelled at any time by contacting ViaCord, regardless of whether my Child is still a minor or has reached the age of majority.

- In the event that I wish to discontinue the Services, and my account is in good standing (i.e., account is current), I agree to sign ViaCord's Termination Agreement and provide proof of my identity.
- In the event that I wish to discontinue the Services, I may donate the Newborn Stem Cells to ViaCord's research or I may instruct ViaCord to destroy the Newborn Stem Cells according to ViaCord's standard operating procedure, which may allow ViaCord to defer destruction of the Newborn Stem Cells until a later time.
- If I instruct ViaCord to destroy the Newborn Stem Cells, the Newborn Stem Cells will not be used for any purpose during the period of time prior to destruction, including but not limited to any therapeutic or research purpose.

In the event that I wish to transfer the Newborn Stem Cells to another appropriate entity (e.g., cord blood bank) and my account is in good standing (i.e., account is current), I agree to inform ViaCord Customer Service in writing of my request to transfer.

- Upon receipt of this request, ViaCord will communicate all transfer requirements to me.
- If I decide to transfer the Newborn Stem Cells during the Term of the Sibling Connection Program, ViaCord may charge me for the collection, processing, and storage of the Newborn Stem Cells.

ViaCord Sibling Connection Program Service Agreement

Release, Limitation of Liability, and Indemnification

I understand that ViaCord makes no representations or warranties with respect to the success of the collection, transportation, testing, processing, cryopreservation, or storage process.

I understand that several external factors such as delays in transportation, extreme temperatures, and improper collection are beyond the control of ViaCord and I agree to hold ViaCord harmless for any deterioration or degradation of the Newborn Stem Cells that are attributable to such external factors.

I understand and agree that ViaCord accepts no liability for any breach of its obligations or other acts or omissions by itself or others, such as the physician/midwife, medical facility, medical staff, and transporters of the Newborn Stem Cells. I understand that the performing physician/midwife in no way acts as an agent for ViaCord.

I understand that both the Services and any eventual transplantation or other medical procedures that may be used in connection with the Newborn Stem Cells involve new techniques and procedures, and that there is no guarantee or assurance of a successful outcome in the event that the Newborn Stem Cells are required for use.

I hereby release ViaCord and its officers, directors, employees, agents, affiliates, successors and assigns from any and all other liability for any and all loss, harm, damage or claim of any kind in connection with ViaCord's Services.

I understand and agree that I am giving up certain rights that I might otherwise have, now or in the future, to sue or otherwise seek monetary damages or other relief against ViaCord for any reason relating to the Services other than the remedies listed in this Agreement, if any.

I understand that ViaCord will not be liable for nonperformance of this agreement (including the loss or destruction of the Newborn Stem Cells) in the event of a force majeure which may include without limitation, natural disasters, strikes, acts of God, war, non-temporary power failures, terrorist attacks, and government regulations.

Confidentiality of Health Information

Appropriate confidentiality will be maintained for all patient records concerning the Services. ViaCord may be required to release or make available information regarding certain positive test results, such as HIV, AIDS, hepatitis C, or other infectious diseases to federal, state, or local government agencies. For additional information regarding ViaCord's Privacy Policy, please visit www.viacord.com/privacy-policy/index.aspx.

Resolution of Disputes

This Agreement will be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts, without giving effect to conflict of laws, rules or principles. This Agreement has been prepared in the English language and the English language shall control its interpretation. All questions, disputes or differences which may arise between the Parties to this Agreement shall, if such questions, disputes, or differences cannot be amicably resolved by the Parties, be referred to arbitration to be held in Boston, Massachusetts in accordance with the Commercial Arbitration Rules of the American Arbitration Association, which rules are deemed to be incorporated by reference into this Section. The arbitrators' decision shall be final and binding upon the Parties and shall provide the sole and exclusive remedies of the Parties. Judgment upon the rendered award may be entered into any court having jurisdiction or application may be made to such court for a judicial acceptance of the award or orders of enforcement.

ViaCord Sibling Connection Program Service Agreement

Entire Agreement

This Agreement contains the entire agreement between the Parties with respect to the Services and supersedes any and all previous agreements and understandings, whether written or oral.

Severability

The provisions of this Agreement are severable. If any part or portion of this Agreement is determined to be invalid or unenforceable, that provision will be modified so that it is valid and enforceable, and this Agreement will otherwise remain in effect.

If there are any questions concerning this Agreement, please contact ViaCord Customer Service at (866) 861-8435 or 800-998-4226.

I have read and understand the information contained in the Agreement, including the Informed Consent. All of my questions regarding the ViaCord Services have been answered to my satisfaction. I certify that all the information I have provided to ViaCord is true and correct to the best of my knowledge. I have signed this Agreement freely and voluntarily.

_____
Parent's Printed Name (required)

_____
Parent's Signature (required)

Signature Date: _____
(mm/dd/yyyy) (required)

_____
Additional Parent's Printed Name (optional)

_____
Additional Parent's Signature (optional)

Signature Date: _____
(mm/dd/yyyy) (required)

We recommend that you make a copy of the completed Service Agreement and questionnaire for your records.

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

THE SIBLING CONNECTION

ViaCord's Newborn Stem Cell Donor Program

Please complete, review, sign and return all pages of this Health History Questionnaire to ViaCord as soon as possible.

Why completing your Health History Questionnaire is so important?

- Without this information, ViaCord will be unable to release your Child's Newborn Stem Cells for therapeutic use in the future.
- This information is required for the potential therapeutic use of the Newborn Stem Cells by your Child or a family member such as a parent, sibling, child, grandparent, aunt, uncle, niece, or nephew.
- ViaCord is required by Federal regulations to ask questions to assess the potential risk for exposure to certain infectious diseases.

Who needs to complete this form:

- The **Biological Mother** must complete all sections of this form.
- Except for New York residents, completing a health history questionnaire is optional for the **Biological Father**. There is a separate form for Fathers to complete. (New York State Department of Health requires that we obtain the health history of the **Biological Father** unless he is unavailable).
- Each person should complete their own separate questionnaire.

What You Need to Know Before Completing this Form:

- The Health History Questionnaire below contains questions that are similar to questions asked when someone donates blood.
- It also contains questions about your behaviors and travel history that you may find to be sensitive and of a personal nature.
- Each question will need to be answered to the best of your ability with a "YES" or "NO." Some questions may require additional information. **Do not leave any questions blank.**
- The information provided is ***confidential*** and will only be shared with you, your physician, the Child's physician, or the Sibling's physician.
- ViaCord may be required to release or make available information regarding certain positive test results, such as HIV, AIDS, Hepatitis C, or other infectious diseases to federal, state, or local government agencies.
- The biological mother will be asked to provide consent for a maternal blood sample.
- See Appendices for Submission Options, Definition of Terms, Medication List, Country Definition List, and Vaccination/Immunization List.

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

PARENT(S) INFORMATION						
Mother's Name (Last, First, M.I.):			**Mother's DOB:**	**Maiden Name:**		
Home Phone:		**Cell Phone:**		**Email:**		
Home Address Street: City:			State:	Zip Code:		
Marital status **(NY Residents Only):**	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Additional Parent's Full Name (Last, First, M.I.):						
Expected Due Date:						
Have you banked with ViaCord before?	☐ YES ☐ NO			**If Yes, When?**		

OBSTETRIC CARE/DELIVERY INFORMATION		
OB/CNM Name:	**OB/CNM Phone:**	**OB/CNM Fax:**
	OB/CNM Address (Street, City, State, Zip Code):	
Delivery Hospital:	**Hospital Phone:**	**L&D Phone:**
	Hospital Address (Street, City, State, Zip Code):	

POTENTIAL RECIPIENT INFORMATION	
Potential Recipient Sibling's Name:	**Date of Birth:**
Diagnosis:	
Treating Physician's Name:	**Physician's Phone Number:**
Physician's Address (Street, City, State, Zip Code):	**Physician's Fax Number:**

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

Please call **(866) 861-8435** if you need assistance in filling out this form

HEALTH HISTORY

Mother's Current Health

The following questions pertain to your current health (Please check EITHER "Yes" or "No" for each.)	Yes	No
Do you currently have an infectious skin disease? If YES, please explain: _____	☐	☐
Are you currently taking an antibiotic? If YES, please answer below:	☐	☐
Antibiotic: _____ Reason for Taking: _____		
Do you currently have any medical condition that could be affected adversely by the collection procedure? (Such conditions may include cancer, diabetes, blood disease, bleeding problems, lung disease, heart disease, chest pain, stroke, seizure or multiple sclerosis) Please consult your physician for any identified medical condition applicable to this question.	☐	☐
Did you undergo any chemotherapy during your pregnancy?	☐	☐

Mother's Clinical Symptoms

If you have had any of the following clinical or physical symptoms and they are <u>UNEXPLAINED</u>, check the appropriate box. If you had none of these symptoms check the N/A – None of The Above Apply to Me.

☐	Muscle weakness or paralysis	☐	Persistent white spots or sores in the mouth
☐	Night sweats	☐	Lumps in your neck, armpits, or groin lasting more than a month
☐	Blue or purple spots on or under the skin or mucous membrane	☐	Jaundice
☐	Weight loss	☐	Hepatomegaly or enlarged liver
☐	Persistent diarrhea	☐	General rash
☐	Cough or shortness of breath	☐	Headaches, body aches, or eye pain
☐	Temperature higher than 100.5 degrees F (38.0 degrees C) for more than 10 days	☐	Fast heart beat
☐	Neck stiffness	☐	Episodes of stupor, disorientation, or tremors

☐ **N/A - NONE OF THE ABOVE APPLY TO ME**

Medications

Please refer to Appendix C: Medication List	Yes	No
Are you now or have you ever taken any medications on the Medication List? If YES, please identify below:	☐	☐
Medication: _____ Last Dose Taken: _____		

Travel

The following questions pertain to areas in which you have lived or to which you have traveled. Please refer to Appendix D Country Definition List.	Yes	No
Have you traveled or lived outside of the United States or Canada in the last 3 years? If YES, Please identify which countries you have traveled to and approximate date(s) (month/year) of travel: List all countries in which you have traveled or lived even if you do not see them on the Country Definition List. Use a separate sheet if needed. Countries Traveled/Lived: _____ Month/Year Traveled/Lived: _____	☐	☐
Since **1980**, have you spent more than a total of **3 months** in the United Kingdom or **Europe** (this includes living, traveling, or serving at a US Military base)?	☐	☐
From **1980** through **1996**, did you live in or travel to Europe as a member of the U.S. Military, a civilian military employee, or a dependent of a member of the U.S. Military?	☐	☐
Since **1980**, have you received a transfusion of blood, platelets, plasma, cryoprecipitate or granulocytes in the United Kingdom, or Europe?	☐	☐
Have you lived in or travelled to a Zika affected area at any time during your pregnancy? Refer to the CDC website (http://www.cdc.gov/zika/areasatrisk.html) for a current list of affected areas.	☐	☐

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

			Yes	No
Past 12 Months	**Thinking back over the past 12 months, have you:**			
	Received blood, blood factor products, derivatives, or a tissue/organ transplant?		☐	☐
	Come into contact with someone else's blood (e.g., accidental needle stick)?		☐	☐
	Had a tattoo, any type of piercing (ear or body), acupuncture, or had a needle gun used on you		☐	☐
	Received shots including Rh immune globulin or vaccinations/immunizations? (Refer Appendix E Vaccination/Immunization List) Please identify all below:		☐	☐
	Shots Received: _____ Date Received: _____			
	Been diagnosed with:	Chikungunya	☐	☐
		Dengue	☐	☐
		West Nile	☐	☐
		Zika Virus	☐	☐
	Been in close contact with someone who was vaccinated for smallpox and you developed a rash or other symptoms related to exposure?		☐	☐
	Been diagnosed with Syphilis or Gonorrhea?		☐	☐
	Lived in the same household as another person who has been diagnosed with Hepatitis B or clinically active Hepatitis C?		☐	☐
	Been in jail, prison, lock up or juvenile detention for more than 72 hours?		☐	☐
	Been bitten by an animal suspected of having rabies within the past 6 months?		☐	☐
	Had sexual contact with a person who has Hepatitis or Jaundice (not Infant Jaundice),		☐	☐
	Had sexual contact with a person with a history of ever testing positive for HIV		☐	☐
	Had sexual contact with a person who takes money or drugs or other payment in exchange for sex?		☐	☐
	Had sexual contact with a man who has ever had sexual contact with another man?		☐	☐
	Had sexual contact with a person who has taken intravenous drugs not prescribed by a physician?		☐	☐
	Had sexual contact at any time during your pregnancy with a man who has been diagnosed with Zika virus infection in the past 6 months?		☐	☐
	Had sexual contact at any time during your pregnancy with a man who lived in or travelled to a Zika affected area within the last 6 months? Refer to the CDC website (http://www.cdc.gov/zika/areasatrisk.html) for a current list of affected areas.		☐	☐
Ever	**Have you ever:**		Yes	No
	Been diagnosed with, or tested positive for:	HTLV	☐	☐
		Hepatitis B	☐	☐
		Hepatitis C	☐	☐
	Been diagnosed with, or tested positive for HIV?		☐	☐
	Been significantly exposed to substances that may be transferred in toxic amounts (e.g., lead, mercury, gold)?		☐	☐
	Been diagnosed with:	Tuberculosis	☐	☐
		Malaria	☐	☐
		Chagas Disease	☐	☐
		Babesiosis	☐	☐
		Acute Respiratory Disease	☐	☐
	Been diagnosed with any form of Creutzfeldt-Jakob Disease (CJD)?		☐	☐
	Have a history of Ebola virus infection or disease?		☐	☐
	Had head or brain surgery with a transplanted brain covering (dura mater)?		☐	☐
	Been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system?		☐	☐
	Had a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal?		☐	☐
	Had intimate contact with a recipient of a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal? Intimate contact includes contact with blood, saliva, and body fluids		☐	☐
	Been deferred as a blood donor *for a reason other than anemia or being underweight?* If YES, please explain: _____		☐	☐
	Abused alcohol or drugs (intravenous, oral, prescription, non-prescription)?		☐	☐
	Taken money, drugs or other payment in exchange for sex?		☐	☐

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

Family Genetic History			
Biological Mother	**Has anyone in your maternal or paternal family:**	Yes	No
	Been diagnosed with any of the following: Aplastic Anemia, Fanconi Anemia, Thalassemia, Chronic Granulomatosis Disease (CGD), Sickle Cell Anemia, Hunter Syndrome, Hurler Syndrome, or any other storage disorder, severe combined immunodeficiency syndrome or blood/bleeding disorders or other genetic disorders? If YES, please explain:_____	☐	☐
	Had Creutzfeldt-Jakob Disease (CJD)?	☐	☐

INFORMED CONSENT FOR MATERNAL BLOOD SAMPLE

I am pregnant with a child. If I am the child's Biological Mother, Egg Donor, or if I am a Gestational Carrier for the biological child of others, I understand and agree to the following:

- I must be assessed by a physician prior to providing this informed consent.
- I must allow the collection of samples of my own blood drawn at the time of the child's delivery. The blood samples will be collected by a doctor, nurse, phlebotomist or mid-wife at the time of delivery.
- I must provide my health history.

I understand that there are risks to having a sample of my own blood drawn, which may include bruising, redness, discomfort, or inflammation around the needle site as well as, in very limited cases, more significant complications.

I authorize ViaCord to test my blood for certain infectious diseases including but not limited to:

- Human Immunodeficiency Virus (HIV)
- Hepatitis B Virus
- Hepatitis C Virus
- Human T-Lymphotrophic Virus (HTLV)
- Cytomegalovirus (CMV)
- Syphilis
- And any other infectious/communicable disease as required under federal or state law.

I understand that testing may result in a decision to store, but they may only be released for transplant or other treatment with the approval of the ViaCord Medical Director and the treating physician. I understand that I will only be contacted by ViaCord in the event that test results for my sample are confirmed positive for HIV, Hepatitis B and C Virus, HTLV, Syphilis, and any other relevant communicable disease as required under federal or state law.

I authorize ViaCord to provide me with test results and to furnish them to my physician and the Child's physician, if applicable, and as described above. The test results may also be used for research purposes and for analyses and in publications, provided that they are aggregated with other data and do not contain donor identification. **For Adoption/Surrogate Cases: ViaCord may not disclose any health information about the Biological Mother/Gestational Carrier to anyone but the Biological Mother/Gestational Carrier and her physician. Any communication about the Biological Mother/Gestational Carrier's health information must be through channels established by your surrogate/adoption contract.**

Appropriate confidentiality will be maintained for all patient records concerning the maternal blood sample. ViaCord may be required to release or make available information regarding certain positive test results, such as HIV, AIDS, Hepatitis C, or other infectious disease to the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services, the Center for Disease Control, or other federal, state, or local government agencies.

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Mother

I understand that I have the right to have my questions answered. If I have any questions regarding this Informed Consent or the Health History Questionnaire, I may contact ViaCord Customer Services at **(866) 861-8435 or 800-998-4226**.

I understand that I have that right to withdraw my consent to collect the maternal blood samples prior to the collection or testing of the samples and that by withdrawing my consent, the Newborn Stem Cells will not be collected, processed, and/or stored, as applicable.

Please review this form carefully before signing to ensure it is complete. Please submit all pages of the Health History Questionnaire.

We recommend that you make a copy of the completed questionnaire for your records and to review with a Customer Service Representative when the baby is born.

I certify that I have read and understand the Informed Consent and answered the Health History questions above truthfully and to the best of my knowledge.

I am the Biological Mother.

Print Name *(full legal name)*	Signature	Date signed (mm/dd/yyyy)

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Father

Please Complete, review, sign and RETURN all pages of this Health History Questionnaire to ViaCord prior to your expected delivery date

Why completing your Health History Questionnaire is so important

- Without this information, ViaCord will be unable to release your Child's Newborn Stem Cells for therapeutic use in the future.
- This information is required for the potential therapeutic use of the Newborn Stem Cells by your Child or a family member such as a parent, sibling, child, grandparent, aunt, uncle, niece, or nephew.
- ViaCord is required to ask questions to assess the potential risk for exposure to certain infectious diseases.

Who Should Complete This Form (See Appendix B for Definition of Terms)**?**

- **New York residents:** New York State Department of Health requires that we obtain the health history of the **Biological Father** (unless he is unavailable.)
- **Except for New York residents,** completing a health history questionnaire is optional for the ***Biological Father.***
- This is a Health History Questionnaire designed specifically for Fathers.
- Complete the entire form. Do not leave any blanks.

What do You Need to Know Before Completing this Form?

- The Health History Questionnaire contains questions that are similar to questions asked when someone donates blood.
- It also contains questions about your behaviors and travel history that you may find to be sensitive and of a personal nature.
- Each question will need to be answered to the best of your ability with a "YES" or "NO". Some questions require additional follow-up information. Do not leave any questions blank.
- The information provided is ***confidential*** and will only be shared with you or the Child's physician
- See Appendices for Submission Options, Definition of Terms, Medication Deferral List, Country Definition List, and Vaccination/Immunization List.

PARENT'S/FATHER'S INFORMATION		
Father's/Parent's Full Name *(Last, First, M.I.):*		
Home Phone:		**Cell Phone:**
Email:		
Home Address	Street Address City State Zip Code	
Marital status (NY Residents Only):	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Additional Parent's/Mother's Full Name *(Last, First, M.I.):*		

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Father

Please call **(866) 861-8435** if you need assistance in filling out this form

Health History

Medication	**Please refer to Appendix C: Medication List**	Yes	No
	Are you **now** or have you **ever** taken any medications on the Medication Deferral List? If YES, please below:	☐	☐
	Medication: _____ Last Dose Taken: _____		
Travel	**The following questions pertain to areas in which you have lived or to which you have traveled. Please refer to Appendix D Country Definition List.**	Yes	No
	Have you traveled or lived outside of the United States or Canada in the last 3 years? If YES, Please identify which countries you have traveled to and approximate date(s) (month/year) of travel: Please list all countries in which you have traveled or lived even if you do not see them on the Country Definition List. Use a separate sheet if needed.	☐	☐
	Countries Traveled/Lived: _____ Month/Year Traveled/Lived: _____		
	Since **1980**, have you spent more than a total of **3 months** in the United Kingdom or **Europe** (this includes living, traveling, or serving at a US Military base)?	☐	☐
	From **1980** through **1996**, did you live in or travel to Europe as a member of the U.S. Military, a civilian military employee, or a dependent of a member of the U.S. Military?	☐	☐
	Since **1980**, have you received a transfusion of blood, platelets, plasma, cryoprecipitate or granulocytes in the United Kingdom, Europe?	☐	☐
	Have you lived in or travelled to a Zika affected area within the last 6 months? Refer to the CDC website (http://www.cdc.gov/zika/areasatrisk.html) for a current list of affected areas.	☐	☐
Past 12 Months	**Thinking over the last 12 months Have you**	Yes	No
	Received blood, blood factor products, derivatives, or a tissue/organ transplant?	☐	☐
	Come into contact with someone else's blood (e.g., accidental needle stick)?	☐	☐
	Had a tattoo, any type of piercing (ear or body), acupuncture, or had a needle gun used on you?	☐	☐
	Received shots or vaccinations/immunizations? (Refer to Appendix E Vaccination/Immunization List) If **YES**, please list below:	☐	☐
	Shots Received: _____ Date Received: _____		
	Been diagnosed with: Chikungunya	☐	☐
	Dengue	☐	☐
	West Nile	☐	☐
	Zika Virus	☐	☐
	Been in close contact with someone who was vaccinated for smallpox and you developed a rash or other symptoms related to exposure?	☐	☐
	Been diagnosed with Syphilis or Gonorrhea?	☐	☐
	Lived in the same household as another person who has been diagnosed with Hepatitis B or clinically active Hepatitis C?	☐	☐
	Been in jail, prison, lock up or juvenile detention for more than 72 hours?	☐	☐
	Been bitten by an animal suspected of having rabies within the past 6 months?	☐	☐
	Had sexual contact with a person who has Hepatitis, Jaundice (not Infant Jaundice),	☐	☐
	Had sexual contact with a person with a history of ever testing positive for HIV	☐	☐
	Had sexual contact with a person who takes money or drugs or other payment in exchange for sex?	☐	☐
	Had sexual contact with a man?	☐	☐
	Had sexual contact with a person who has taken intravenous drugs not prescribed by a physician?	☐	☐

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE
Father

			Yes	No
Ever	**Have you ever:**			
	Been diagnosed with, or tested positive for:	HTLV	☐	☐
		Hepatitis B	☐	☐
		Hepatitis C	☐	☐
	Been diagnosed with, or tested positive for HIV?		☐	☐
	Been significantly exposed to substances that may be transferred in toxic amounts (e.g., lead, mercury, gold)?		☐	☐
	Been diagnosed with:	Tuberculosis	☐	☐
		Malaria	☐	☐
		Chagas Disease	☐	☐
		Babesiosis	☐	☐
		Acute Respiratory Disease	☐	☐
	Been diagnosed with any form of Creutzfeldt-Jakob Disease (CJD)?		☐	☐
	Have a history of Ebola virus infection or disease?		☐	☐
	Had head or brain surgery with a transplanted brain covering (dura mater)?		☐	☐
	Been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system?		☐	☐
	Had a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal?		☐	☐
	Had intimate contact with a recipient of a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal? Intimate contact includes contact with blood, saliva, and body fluids		☐	☐
	Been deferred as a blood donor *for a reason other than anemia or being underweight?* If YES, please explain: _____		☐	☐
	Abused alcohol or drugs (intravenous, oral, prescription, non-prescription)?		☐	☐
	Taken money, drugs or other payment in exchange for sex?		☐	☐
Family Genetic History**				
Biological Father	**Has anyone in your maternal or paternal family:**		Yes	No
	Been diagnosed with any of the following: Aplastic Anemia, Fanconi Anemia, Thalassemia, Chronic Granulomatosis Disease (CGD), Sickle Cell Anemia, Hunter Syndrome, Hurler Syndrome, or any other storage disorder, severe combined immunodeficiency syndrome or blood/bleeding disorders or other genetic disorders? If **YES**, please explain: _____		☐	☐
	Had Creutzfeldt-Jakob Disease (CJD)?		☐	☐

Please review this form carefully before signing to ensure it is complete. Please submit all pages of the Health History Questionnaire.

We recommend that you make a copy of the completed questionnaire for your records and to review with a Customer Service Representative when the baby is born.

I certify that I have answered all of the questions above truthfully and to the best of my knowledge.

I am the Biological Father.

Print Name *(full legal name)*	Signature	Date signed (mm/dd/yyyy)

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE

Appendix A: Form Submission Options (Fax, Mail, or Email)

Option 1: EMAIL your completed forms to: siblingconnection@viacord.com

Option 2: MAIL your completed forms to:

ViaCord
Attn: Sibling Connection
940 Winter St.
Waltham, MA 02451

Option 3: FAX your completed forms to: 781-663-8099 (using the Fax Cover sheet provided in this packet

Appendix B: Definition of Terms

- **Newborn Stem Cells** refer to the cord blood stem cells that are found in the umbilical cord of the child who is being delivered.
- **Biological Mother** refers to a woman who is pregnant with a child and the child she is giving birth to shares her DNA.
- **Biological Father** refers to a man who shares his DNA with a child.

Appendix C: Medication List

Please tell us if you are now taking or if you have **EVER** taken any of the following medications:

- Accutane©, Absorica, Amnesteem, Claravis, Myorisan, Sotret, Zenatane (isotretinoin) for treatment of severe acne
- Erivedge (Vismodegib) for treatment of basal cell skin cancer
- Soriatane© (acitretin) for treatment of severe psoriasis
- Human-derived clotting factor concentrates (Number of occasions: _____)
- Insulin from a cow source
- Growth hormone from human pituitary glands (not infertility hormones)
- Tegison© (etretinate) for treatment of severe psoriasis
- Proscar© (finasteride) for treatment of prostate gland enlargement
- Avodart©, Jalyn (dutasteride) for treatment of prostate enlargement
- Propecia© (finasteride) for baldness

IF YOU WOULD LIKE TO KNOW WHY THESE MEDICINES AFFECT THE THERAPEUTIC USE OF THE NEWBORN STEM CELLS, PLEASE KEEP READING:

- If you have taken or are taking **Proscar©, Avodart©, Jalyn, Propecia, Accutane©, Absorica, Amnesteem, Claravis, Myorisan, Sotret, Soriatane©, Tegison**, Erivedge, Vismodegib or **Zenatane** these medications can cause birth defects.
- **Growth hormone from human pituitary glands** was prescribed for children with delayed or impaired growth. The hormone was obtained from human pituitary glands, which are found in the brain. Some people who took this hormone developed a rare nervous system condition called Creutzfeldt-Jakob Disease (CJD, for short).
- **Insulin from cows (bovine, or beef, insulin)** is an injected material used to treat diabetes. If this insulin was imported into the US from countries in which “Mad Cow Disease” has been found, it could contain material from infected cattle. There is concern that "Mad Cow Disease" is transmitted by transfusion.
- **Experimental Medication** is usually associated with a research protocol and the effect on blood is unknown.

SIBLING CONNECTION PROGRAM
HEALTH HISTORY QUESTIONNAIRE

Appendix D: Country Definition List

Please list all countries in which you have traveled or lived even if you do not see them on this list.

A list of areas with active transmission of Zika can be found on the Centers for Disease Control (CDC) website (http://www.cdc.gov/zika/areasatrisk.html).

All countries in Central America, South America, Mexico, Caribbean, Puerto Rico, Pacific Islands

United Kingdom includes the following countries:

- England
- Northern Ireland
- Scotland
- The Isle of Man
- The Channel Islands
- Gibraltar
- Wales
- The Falkland Islands

Europe includes the following countries:

- Albania
- Austria
- Belgium
- Bosnia-Herzegovina
- Bulgaria
- Croatia
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greece
- Hungary
- Ireland
- Italy
- Liechtenstein
- Luxembourg
- Macedonia
- Netherlands
- Norway
- Poland
- Portugal
- Romania
- Slovak Republic
- Slovenia
- Spain
- Sweden
- Switzerland
- United Kingdom (see above)
- Yugoslavia

Africa includes the following countries:

- Benin
- Cameroon
- Central African Republic
- Chad
- Congo
- Equatorial Guinea
- Gabon
- Kenya
- Nigeria
- Niger
- Senegal
- Togo
- Zambia

Appendix E: Vaccination/Immunization List:

- Live vaccines (e.g., Measles, Mumps, Herpes Zoster)
- Vaccinations for Smallpox, typhoid, yellow fever, Japanese Encephalitis
- Hepatitis B Immune Globulin (for exposure)
- Experimental vaccines
- Rabies Vaccine (for exposure)

IF YOU WOULD LIKE TO KNOW WHY THESE Vaccines/Immunizations AFFECT THE THERAPEUTIC USE OF THE NEWBORN STEM CELLS, PLEASE KEEP READING:

- **Hepatitis B Immune Globulin (HBIG)** is an injected material used to prevent infection following an exposure to hepatitis B. HBIG does not prevent hepatitis B infection in every case.
- **Unlicensed (Experimental) Vaccine** is usually associated with a research protocol and the effect on blood is unknown.