EXHIBIT A

ART Reproductive Center, Inc.
450 N. Roxbury Drive, Suite 520
Beverly Hills, CA 90210

GENERAL INFORMED CONSENT FOR PROCEDURES INVOLVED IN:
□ OOCYTE (GIFT) □ ZYGOTE (ZIFT) □ EMBRYO INTRAFALLOPIAN TUBE TRANSFER (TET) ☑ IN VITRO FERTILIZATION (IVF) ***(Please check appropriate box)***

We, _____ (Patient) and _____ (Partner), have been informed by our physician, Dr. Chase, about and understand the reasons for carrying out the procedures outlined below, and accept the consequences and risks of such procedures. We understand that our physician is responsible for the provision of medical services discussed herein.

The procedures may include:

1. Stimulation of the ovaries by hormonal drugs.
2. Collection of oocytes and granulosa cells by ultrasound guided follicle aspiration.
3. Preparation of spermatozoa isolated from semen or testicular tissues.
4. Addition of spermatozoa to oocytes by conventional or assisted means (ICSI).
5. Observation and handling of oocytes, spermatozoa and embryos.
6. Co-culturing of embryos, if indicated.
7. Placement of embryos into the uterus or fallopian tubes as indicated.
8. Maintenance of uterine environment by hormonal drugs.
9. Freezing and storage of embryos if we request it, and as deemed appropriate.

As part of her initial evaluation, the Patient will complete a medical and genetic history, as well as a physical exam. Furthermore, we understand that both Patient and Partner will undergo testing for infectious diseases as we acknowledge that it is the policy of the ART Reproductive Center that no tissue shall be transferred into the body of another person by means of transplantation unless the donor of the tissue has been screened and found non-reactive by laboratory tests for evidence of infection with HIV 1&2, agents of viral Hepatitis (HBV & HCV), Human T Lymphotrophic Virus (HTLV I &II) and Syphilis. (Reference California Health & Safety Code section 1644.5(a).)

We understand that in order to produce several eggs, the Patient will be required to take medication on a specific schedule to stimulate her ovaries. These medications may produce temporary development of follicular cysts of the ovaries. Rarely would such changes produce severe complications (such as twisting of the ovary, rupture of ovary, or fluid/electrolyte problems) that would require hospitalization. As a result of taking this medication, there is a chance that the Patient would be required to restrict strenuous and/or sexual activity for 1-2 weeks, and in cases involving pre-implantation genetic testing, for an additional 2 weeks following embryo transfer.

We recognize that egg retrieval involves the use of a vaginal ultrasound probe and attached needle guide to allow insertion of a needle through the vagina and into the ovary/ovaries. There is the potential for intra-abdominal bleeding, damage to the ovaries, and/or infection that could potentially render the Patient sterile, but clinical experience suggests that the risk of these eventualities is very low. The egg collection procedure will require intravenous general anesthesia. The procedure generally lasts approximately thirty (30) minutes.

After the eggs have been recovered, they may be treated as follows: the eggs may be combined with sperm and fertilized within the laboratory. The eggs will be carefully examined to see if fertilization has occurred and (later) if normal embryonic development has taken place. There are many reasons why eggs fail to fertilize, and while the IVF laboratory's policies and procedures attempt to minimize this possibility, laboratory error or unexplainable factors can and occasionally do occur. In spite of reasonable precautions, any of the following may occur in the lab that would prevent the establishment of a pregnancy: 1) Fertilization of the oocyte(s) may fail to occur 2) One or more of the oocytes may be fertilized abnormally resulting in an abnormal number of chromosomes in the embryo 3) The fertilized oocytes may degenerate before becoming embryos, or adequate embryonic development may fail to occur 4) Contamination or other laboratory accident or failure may result in loss or damage to some or all of the oocytes or embryos.

Selected embryos may then be transferred into the uterus (IVF-ET) through a small catheter placed through the cervix. We understand that if more embryos develop in the IVF Laboratory than can be safely transferred to the uterus in attempting to establish pregnancy, these "extra" embryos may be frozen for our future use.

Thawed, previously cryopreserved embryos will be assessed for viability, and if viable, transferred into the Patient's uterus as described above. This procedure is known as a Frozen Embryo Transfer (FET).

Replacement of gametes (sperm or eggs) or embryos must occur at an appropriate time in the Patient's menstrual cycle. Timing of the Patients' menstrual cycle will be determined by our physician. Placement of embryos for IVF-ET or FET involves the insertion of a small flexible tube containing the embryos, which are gently expelled into the fallopian tube or uterine cavity.

We understand that there is no guarantee that the Patient will become pregnant as a result of the procedures, and that if a pregnancy is established and carried to term, there is no

guarantee that the child will be normal. Most studies throughout the world looking at birth outcomes of now several million IVF-derived pregnancies have concluded that children resulting from IVF-ET or FET procedures have not displayed a higher incidence of abnormalities than the general population.

We have been advised and understand the risk of IVF-ET and FET procedures include, but without limitation to, the possibility of tubal (ectopic) pregnancy needing surgical treatment, multiple pregnancy and miscarriage. All pregnancies carry with them the risk of major surgery to affect delivery and the possibility of major complications including hemorrhage, stroke and even death.

We acknowledge that success in any of the procedures cannot be guaranteed. Our physician has informed us of the generally expected chance of pregnancy in the procedure. We have been informed by our physician of the expected chance of pregnancy when multiple embryos are replaced, and have been informed of the probability of twins or triplets when more than one embryo is replaced.

We agree to our physician, or his or her associate carrying out any further surgical or medical procedure, in connection with the oocyte retrieval or embryo replacement if these are judged to be necessary.

We agree to the treatment being abandoned if for any medical reason our physician or the staff of the ART Reproductive Center does not think it wise or appropriate to continue.

We understand that the records for this procedure are confidential. Scientific data about the program may be published, but this data will not contain patient identifying information.

We understand that we will be responsible for paying the costs of these procedures, including but not limited to: the oocyte retrieval, laboratory in vitro fertilization, embryo development, embryo storage, embryo transfer and any surgical complications.

Our signatures on this form indicate that: (1) we have read through and understand to our satisfaction the information provided in this form, including all terminology used in describing the ART processes; (2) we understand that this form cannot possibly include all of the information that is relevant to the procedure in question, and we have had the opportunity to ask questions of our physician about ART Reproductive Center as well as the contents of this form, and our questions have been answered to our satisfaction; (3) we have had a sufficient amount of time to think about and consider our decision; and (4) we hereby authorize and consent to use ART Reproductive Center for our IVF procedure. If we have additional questions about any information in this form, we understand that we can contact our IVF physician.

RELEASE

We agree to release and hold harmless the ART Reproductive Center and any other entity, employees, agents, or directors related to or affiliated with the forgoing entity in any way,

from and against any and all liability, damages, claims or costs which arise out of or related to the procedure mentioned above.

Patient and Partner hereby waive and relinquish the rights and benefits afforded by Section 1542 of the California Civil Code, which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

Signed:

Patient _____ Date NOV 16 2013

Partner _____ Date 11/16/2013

Witness _____ Date 11/16/13

ART Reproductive Center, Inc.
450 N. Roxbury Drive, Suite 520
Beverly Hills, CA 90210

INFORMED CONSENT REGARDING OOCTYE RECOVERY

Patient Name:_

1. My Physician and surgeon is Dr. Dr Wendy Chang
(Name of physician)

   I understand that he/she is responsible for the provision of medical services discussed in this document.

2. The ART Reproductive Center (the "Center") maintains personnel facilities to assist my physician in the performance of various surgical operations and other special diagnostic therapeutic procedures. These operations and procedures may all involve risks and unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to the result or cure.

3. I have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. I also have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, operations or procedures are not performed until I have had the opportunity to receive this information and have given my consent. I have the right to consent to or refuse any proposed operation or procedure at any time prior to its performance.

4. My physician has recommended the following operation or procedure:

   OOCYTE RECOVERY BY ULTRASONICALLY GUIDED NEEDLE ASPIRATION (ULTRASOUND RETRIEVAL)

5. My physician has discussed with me the procedure referred to as "ultrasound retrieval". The usual method involves recovery of oocytes (eggs) from the ovaries by guiding a needle, via ultrasound, through the vaginal wall and into the ovaries. I understand that this procedure will require the use anesthesia. I understand that in some instances it may not be technically possible to recover my eggs by ultrasound retrieval, and in this case I authorize my physician to attempt egg retrieval by laparoscopic, percutaneous or transabdominal means.

6. It has been explained to me that there is a risk of infection, bleeding and injury to the bladder, intestine, uterine tubes, ovaries or other pelvic structures which could require operative repair including major abdominal surgery. I understand that I (or in case of ovum donation, the ovum recipient) will be financially responsible for any charges that could arise as a result of such complications.

7. To make sure that I fully understand the operation or procedure, my physician will fully explain the operation or procedure to me before I decide to give consent. If I have any questions, I am encouraged and expected to ask them.

8. My signature on this form indicates that: (1) I have read and fully understand the information provided in this form; (2) I understand that it cannot possibly include all of the information that is relevant to the procedure in question, and the operation or procedure set forth above has been more fully and adequately explained to me by my physician; (3) I have had a chance to ask questions; (4) I have received all of the information I desire concerning the operation or procedure; and (5) I authorize and consent to the performance of the operation or procedure.

Signed:

Patient _____ Date Nov 16 2013

Witness _____ Date 11/16/13

ART Reproductive Center
450 North Roxbury Drive, Suite 520
Beverly Hills, CA 90210
Phone: 310-246-4621 Fax: 310-246-4626

Written Consent for Use of Unfertilized Eggs, Abnormally Fertilized Eggs/ Embryos, Leftover Sperm or Follicular Cells for Research Purposes

Notice to All Patients: You might wonder if, by agreeing to donate materials from your procedures, you might in some way be reducing your chances for a pregnancy. Nothing matters more to ART staff than your successful outcome, and we would never propose - let alone do - anything with your eggs, sperm, embryos or "by-product" materials that would reduce your chances for success in any way whatsoever.

1. Overall, about two-thirds of all mature eggs collected at egg retrieval will fertilize in vitro. Of all those that do, about 5% will fertilize abnormally. These abnormally fertilized eggs, along with unfertilized eggs as well as leftover sperm, follicular cells and fluid, are discarded. These specimens offer a priceless opportunity for the embryology team to conduct scientific training and research. Under no circumstances would unfertilized eggs, abnormally fertilized eggs, sperm or specific embryos donated for the above purposes be used to establish a pregnancy in any person.

2. I / We will not be identified in any way with any published results that may come from investigations on any materials donated to education and research.

3. In addition to ethical research, investigations of various kinds and education of ARTs technical team, abnormal embryos and other normally discarded materials can be specifically donated to stem cell research efforts by the Center. These early human embryos may be used to derive pluripotential stem cells and the cells may be used, at some future time, for human transplantation research.

4. All identifiers associated with abnormal embryos any other donated tissue will be removed prior to use in derivation of human pluripotential stem cells. Additionally,

5. I / We will not receive any information about subsequent testing on unfertilized or abnormally fertilized eggs, embryos or the derived pluripotential stem cells, or research results.

6. Derived cells or cell lines, with all identifiers removed, may be kept by the Center in the Cryobank section of the facility for many years.

7. There is a possibility that the donated material may have commercial potential, and that I / We will not receive financial or any other benefits from any future commercial development in connection with the donated material.

8. Research on unfertilized or abnormally fertilized eggs, or pluripotential stem cells derived from embryos is not intended to provide direct medical benefit to me / us.

9. Early human embryos donated for research or scientific training will not be transferred to a woman's uterus, will not survive the pluripotential stem cell derivation process, and will be handled respectfully, as appropriate for all human tissues used in research.

10. If we do not consent to some or all of the above mentioned investigations, it will in no way affect our treatment at this facility.

11. My / Our signature(s) below indicate that I / We (circle one) **do / do not** consent to have our unfertilized eggs, fertilized materials or embryos donated to general research.

12. My / Our signature(s) indicate that I / We (circle one) **do / do not** consent have our unfertilized eggs, fertilized materials or embryos donated to stem cell research.

NOTICE TO PATIENT: THIS WRITTEN CONSENT IS AN IMPORTANT DOCUMENT THAT SHOULD BE RETAINED WITH OTHER VITAL RECORDS

Signed:

Patient _____ Date Nov 16/2013.

Partner _____ Date 11/16/2013

Authorized Signatory for the Center _____ Date 11/16/13

Witness _____ Date 11/16/13

ART Reproductive Center, Inc.
450 N. Roxbury Drive, Suite 520
Beverly Hills, CA 90210
310-246-4621

OOCYTE MICROMANIPULATION CONSENT FORM

Patient: _____

Partner: _____

Our Physician and surgeon is Dr. W. Chang. We understand that he/she is responsible for the provision of medical services discussed herein.

The ART Reproductive Center (the "Center") maintains personnel and facilities to assist our physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks or unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

We have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available alternative methods of treatment and their risks and benefits. We also have the right to be informed whether our physician has any independent medical research or economic interest related to the performance of the proposed procedure. We have the right to consent to or to refuse any proposed procedure at any time prior to its performance.

Our physician and surgeon may recommend the following procedure:

OOCYTE MICROMANIPULATION by INTRACYTOPLASMIC SPERM INJECTION (ICSI)

Intracytoplasmic Sperm Injection (ICSI) – Since 1992, the ICSI procedure has led to thousands of healthy births the world over. ICSI does not guarantee fertilization, but ICSI greatly improves the chances of fertilization in cases of male factor or "unexplained" infertility. ICSI involves the injection of a single sperm cell directly into a mature egg. Eggs treated in this way fertilize and begin dividing just as they would by routine or "conventional" in vitro fertilization methods. ICSI is the most popular fertilization method for low sperm counts or motility, as well as for sperm obtained directly from a patient's testes or epididymis.

We understand that it is a procedure designed to help the fertilization process, and, as is the case with other commonly used techniques in IVF laboratories, there is no guarantee of success. We understand and agree that the decision to perform an embryo transfer with

embryos resulting from this procedure will be based primarily on the opinion of the Center's scientific staff as regards their suitability for embryo transfer.

By signing this form, we acknowledge that it cannot possibly include all of the information that is relevant to the procedure in question; the micromanipulation (ICSI) procedure has been explained more fully to us by our physician, and any and all of our questions have been answered to our satisfaction; we hereby consent to the procedure.

Signed:

Patient _____ Date NOV 16/2013

Partner _____ Date 11/16/2013

~~Witness~~ _____ Date 11/16/13

ART Reproductive Center, Inc.
450 N. Roxbury Drive, Suite 520
Beverly Hills, CA 90210
310-246-4626

EMBRYO MICROMANIPULATION CONSENT FORM

Patient: _____ _____

Partner: _____ _____

Our Physician and surgeon is Dr. _____. We understand that he/she is responsible for the provision of medical services discussed herein.

The ART Reproductive Center (the "Center") maintains personnel and facilities to assist our physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks or unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

We have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available alternative methods of treatment and their risks and benefits. We also have the right to be informed whether our physician has any independent medical research or economic interest related to the performance of the proposed procedure. We have the right to consent to or to refuse any proposed procedure at any time prior to its performance.

Our physician and surgeon may recommend the following procedure:

EMBRYO MICROMANIPULATION by ASSISTED HATCHING (AH)

Assisted Hatching of Embryos – Assisted Hatching, involves creating a small opening in the shell-like covering that surrounds all human embryos. All embryos must create this hole themselves in order to "hatch" from the shell and then implant themselves onto the uterine lining to begin a pregnancy. Studies have demonstrated that in many instances assisting the embryo in this process is beneficial. In patients of advanced maternal age, embryos that have certain atypical growth features or that have thicker than usual "shells" are candidates for the AH procedure.

Performing AH takes just a few minutes in the ART laboratory, and is performed by a trained embryologist. Risk of AH damaging the embryo is low. Patients whose embryos are to

receive AH generally begin a short course of oral medication to improve the chance of AH-treated embryos implanting safely in the uterine lining.

We understand that it is an investigational procedure designed to help the implantation process, and expect no guarantee of success. We understand and agree that the decision to perform an embryo transfer with embryos receiving from this procedure will be based primarily on the opinion on the Center's scientific staff as regards their suitability for embryo transfer.

By signing this form, we acknowledge that it cannot possibly include all of the information that is relevant to the procedure in question; the AH procedure has been explained more fully to us by our physician, and any and all of our questions have been answered to our satisfaction; we hereby consent to the procedure.

Signed:

Patient _____ Date Nov 16 2013

Partner _____ Date 11/16/2013

Witness _____ Date 11/16/13

ART Reproductive Center, Inc.
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Beverly Hills, CA 90210
310-246-4626

CONSENT FOR TRANSFER OF EMBRYO(S)

A transfer of multiple embryos increases the possibility of multiple births and the associated obstetrical, maternal and financial risks. Each embryo transferred has an individual chance of implanting, and it is possible that all embryos transferred may implant.

Selection of the number of embryos transferred is dependant on the woman's age, quality of embryos and the number of cells in each embryo. This selective process has resulted in good pregnancy rates, but with a substantial risk of multiple gestation in women receiving 4 or more embryos. Twins are the most frequent case of multiple gestation. High order multiple gestation (triplets of higher) occurs with a 3% to 5% frequency.

To increase the likelihood of a successful pregnancy outcome, your physician may recommend a Selective Reduction, a process in which higher order multiples may be reduced. Selective Reduction appears to be an effective and safe procedure with a 3% to 5% chance of complications, including pregnancy loss.

Your signature below indicates that you understand the risk of multiple gestation, that you have been informed of the possibility of replacing fewer embryos to minimize the risk, and that your fertility specialist has discussed the option of elective reduction if a higher order multiple gestation occurs.

Number of embryos we wish to have transferred (to be filled in on transfer day) _____

Signed:

Patient Signature _____ Date 11/16/2013

Partner Signature _____ Date 11/16/2013

Witness Signature _____ Date 11/16/13

ART Reproductive Center, Inc.
450 N. Roxbury Drive, Suite 520
Beverly Hills, CA 90210

DECLARATION OF DONOR/RECIPIENT RELATIONSHIP
NEEDS TO BE SIGNED BY UNMARRIED COUPLES ONLY

The ART Reproductive Center (the "Center") is licensed by the California Department of Health Services (DHS) and follows the voluntary standards and guidelines developed by the American Society for Reproductive Medicine (ASRM) and the American Association of Tissue Banks (AATB). As such, the Center follows their standards and makes every effort to protect the recipient from sexually transmitted diseases.

The Center is sensitive to the difficulty many people have in answering highly personal questions. We wish to assure you that there is an absolute need to establish certain facts regarding the relationship between the sperm donor and the intended recipient of the donor's semen specimens.

Where an intimate, sexual relationship exists between the donor and the recipient, the risk of exposure to sexually transmitted diseases by use of the donor's semen in assisted reproductive technology is no greater than that which exists in their current relationship.

When the donor and recipient have not had an intimate, sexual relationship, the Center must take measures to minimize the risk of exposure to sexually transmitted diseases.

I, _____ (recipient's name) have read and understand this document and certify that I am currently in an intimate, sexual relationship with _____ (partner's name). I further certify that I will not be placed at NEW risk of exposure to sexually transmitted diseases by receiving sperm, or embryos generated through use of said sperm from my partner identified hereon.

Patient's signature:_____ Date: Nov 16 | 2013

I, _____ (partner's name) have read and understand this document and certify that I am currently in an intimate relationship with _____ (patient's name). I further certify that the recipient will not be placed at NEW risk of exposure to sexually transmitted diseases by receiving sperm, or embryos resulting from use of said sperm, from me.

Partner's signature:_____ Date: 11/16/2013

Witness signature:_____ Date: 11/16/13

DIRECTIVE FOR PARTNERS REGARDING THE STORAGE AND DISPOSITION OF CRYOPRESERVED MATERIALS WHICH MAY INCLUDE EMBRYOS

We, _____ (Patient) and _____ (Partner), are receiving fertility treatment at the ART Reproductive Center (the "Center") in association with Roxbury Surgery Center located at 450 North Roxbury Drive, Suite 520, Beverly Hills, CA 90210. The ART Center has provided us with this blank Directive form.

We have discussed the provision of medical services by our physician, Dr. Chang and the Center's personnel and facilities which assist the physician in the performance of cryopreservation of our embryos. We have discussed fertility treatment options with our physician and with full knowledge and consent have decided to undergo treatment that may create embryos.

The purpose of this document is to declare our intentions and desires with respect to the storage, use and disposition of our cryopreserved material which may include embryos which are created by and stored at the Center.

Storage

The Center will maintain and use Cryopreserved Material as follows:

a. So long as Patient and Partner continue participation in the IVF and Cryo Programs, the Cryopreserved Material shall be stored exclusively (i) to preserve the opportunity of thawing it, and (ii) for transfer by the Center at the Center of any resulting embryos into the Patient.

b. Patient and Partner shall pay in a timely manner the Center's prevailing charges for participation in the Cryo Program. Payment for each Storage Period shall be due at the commencement of that Storage Period, and each renewed period shall be at the then current rates. Prevailing charges are subject to change at any time but current charges have been provided to me in writing. (Refer to ART Fee Schedule)

c. Unless otherwise directed by both of us in writing in person at ART or by notarized letter, the Center shall continue to store the Cryopreserved Material for an indefinite period of time. At the end of any Storage Term, ART will send out notice of renewal. Unless Patient notifies ART of termination within thirty (30) days of such notice, Patient will be renewed automatically for successive periods of 12 months at the then current rate and is responsible for those storage fees. Patient hereby agrees that such notice sent by ART to the most recent address provided by Patient shall be deemed sufficient to meet this notice requirement and that it is the Patient's responsibility to keep Patient's contact information current. In the event that Patient fails to keep Patient's account current, Patient agrees he/she is responsible for all past due balances.

Disposition of Cryopreserved Materials

We declare that together we have reached a mutual decision and are in agreement regarding the disposition of Cryopreserved Materials, which may include embryos. We declare that in the event of death of either one or both of us, our mutual intention and desire regarding the disposition of Cryopreserved Material is described below.

For each possible event, we have the choice of having the Cryopreserved Material:

- Donated to research; will go to the Center for the purposes of clinical research with the understanding that the materials will never be used for procreative purposes. Specimens are used for on-site research and training by and for the laboratory staff of the Center and disposed of in accordance with FDA and OSHA guidelines.
- Thawed with no further action; which will result in its permanent and irretrievable destruction. All Cryopreserved materials will be thawed by a member of the lab staff of the Center.
- Used by the living partner. If the Cryopreserved Material is used by my partner after my death, it is my desire and stated intention that the child be recognized in law as my child. (Applies to question 1 below only)

1. **Disposition in the event of my death, or my partner's death.**
In the event of the death of either the Patient or Partner, the embryo's disposition shall be of as follows: **(Note: write-in one choice listed above and both parties initial)**

Thawed with no further action.

2. **Disposition in the event of death of both partners.**
In the event of death of both partners, the embryo's disposition shall be of as follows:
(Note: write-in one choice listed above and both parties initial)

thawed with no further action

Disposition in Case of Abandonment

Abandonment is defined by the Center as documented evidence that all reasonable attempts to contact me/us by telephone and registered mail services via the contact information provided on this form have failed. Failure to pay the prevailing annual storage contract fees as set by the Center does not constitute abandonment in and of itself. Failure to pay annual storage fees after all reasonable attempts have been made by the Center to collect said fees after 90 days from the last billing date will automatically result in the notification to a

collection agency. It is the responsibility of the patient(s) to keep contact information current and on file with the Center's Cryobank Services (310-246-4621 x257). In the event of non-payment after two years, the authority for disposition of the cryopreserved materials will revert to the Center. (Not to be used for procreative purposes)
[Note: write-in "I UNDERSTAND AND AGREE" and both parties initial]

I understand and agree -

We understand and are aware that we may change this Directive. However, any and all changes must be mutually agreed to between both named partners. One person cannot use the Cryopreserved Material to create a child (whether or not he or she intends to rear the child) without explicit written consent of the other person (either by notary or witnessed by ART Physician staff member or ART staff). All changes must be in writing and signed by both parties. Unilateral changes cannot be honored by the Center. We must provide a certified copy of any changes to our intentions regarding our Cryopreserved Material to the Center. In the event that we cannot reach a mutual agreement with respect to the disposition of Cryopreserved material, the most recently executed directive in the medical records held by the Center will govern the disposition of any Cryopreserved Material.

In addition to non-payment of storage charges, failure to make a mutual decision about continued storage, use and disposition of Cryopreserved Materials and to notify the Center of the decision by providing them with a certified copy of this executed document will result in the abandonment of the Cryopreserved Material to the Center as described above. All authority and responsibility shall pass to the Center and the Center shall have the right, permission and authority to dispose of or use the Cryopreserved Material.

This Directive is made and entered into the State of California and shall be interpreted under the laws of the State of California. This Directive has been entered into freely and without coercion or duress. Each party has had the opportunity to be represented by an attorney and to ask questions about this Directive.

CRYOPRESERVATION OF HUMAN EMBRYOS

A. We (the undersigned Patient and Partner), by our signatures below, affirm our acknowledgement and understanding of the matters set forth in this Agreement and in particular, in this informed consent section of this Agreement. Our IVF physician is responsible for the provision of medical services discussed in this document. We understand the provision of medical services discussed in this document. We understand that the Center maintains specialized personnel and facilities to assist our physician in the performance of cryopreservation of our embryos. We understand that cryopreservation is a clinical procedure performed under the direction of physicians or other professionals of the IVF Program and the Cryo Program. It is designed to initiate a successful pregnancy after cryopreservation of human embryos. We understand that participation in this clinical procedure is voluntary, and that we are free to withdraw our consent and to discontinue

our participation at any time. Our refusal to participate in or withdrawal from the Cryo Program will not involve any penalty or loss of medical treatment to which we are otherwise entitled and will not affect our participation in the IVF Program. However, if pregnancy occurs, we acknowledge and agree that observation by the IVF Program is important from time to time throughout the pregnancy unless we notify the IVF Program in writing of our objection to the observation.

B. We have read this document carefully and know we should ask questions about anything that is unclear before we decide whether to be participants in this procedure, and that our physician will be happy to answer any of our questions.

C. The Cryo Program is used in the event that we produce more embryos than is considered safe by the physician to transfer in the fresh IVF treatment cycle. All excess embryos will be cryopreserved based on their suitability for this procedure determined by the IVF laboratory technical specialists.

D. We further understand that this procedure is intended to benefit us personally by reducing the risk of multiple births and their obstetric complications, while at the same time creating additional opportunities for the initiation of pregnancy at a later date with the transfer of concepti developed from frozen/thawed embryos. As an alternative we may elect to discard any excess embryos.

E. We understand that embryo Cryopreservation will be conducted as follows: Laboratory personnel will transfer the embryos in a special solution containing a cryo-protectant compound. Embryos will be cooled in a machine designed to carefully control the rate of freezing. Embryos are then transferred to storage containers and maintained in a frozen condition until they are thawed. Frozen embryos are thawed at room temperature. After thawing, the embryos are washed free of the freezing solutions and treated in a manner identical to that used in the IVF laboratory for non-frozen embryos.

F. We understand that laboratories worldwide now have the ability to cryopreserve human embryos and to establish pregnancy after transfer. Many babies have been born subsequent to the transfer of such frozen/thawed embryos. Studies of these human embryos and extensive investigations of cryopreserved animal suggest no increase in risk abnormalities in offspring that had been cryopreserved. This does not mean that Cryopreservation eliminates the normal risk of obstetric complications or fetal abnormalities, but rather that Cryopreservation does not appear to create an increased risk, although the possibility of presently unforeseen risk cannot be completely eliminated.

G. Any information obtained during these procedures that can be identified with us will remain confidential and will be disclosed to individuals not connected with this project only with our written permission. We understand that although photographs or videotapes may be taken of the embryos during the cryopreservation procedures as a permanent record and for possible use at medical meetings or with the lay public for educational purposes, such records will not be identified with us personally. We understand that we have the right to review these records at any reasonable time, and we acknowledge and agree that any government agency with legal authority to do so may also review such records.

H. We understand that with any technique necessitating mechanical support systems, equipment failure may occur. The Center, nor any other entity related to or affiliated with the foregoing entity in such a way shall be held liable for destruction, damage, improper freezing, maintenance, storage, withdrawal, thawing and/or delivery caused by or resulting from any malfunction of the storage tank, failure of utilities, strike, cessation of services or other labor disturbance, any fire, wind, earthquake, water or other acts of God, or the failure of any other laboratory involved with either freezing, storage or transfer of the embryos.

In consideration of being accepted into the IVF and Cryo Programs of the Center, Patient and Partner release, to the maximum extent permitted by law, the Center, and any other entity, employees, agents, or directors related to or affiliated with the foregoing entity in any way, from any and all claims arising from Patient's and Partner's involvement with the IVF program, the Cryo Program, or any activity related to those two programs, including, but not limited to, claims for mental suffering, emotional distress, failure to achieve pregnancy, representations to the likelihood or rate of success in achieving pregnancy, or any related cause of action or basis for liability. Partners further agrees to indemnify, defend, and hold harmless the Center and its past, present, or future officers, directors, employees, agents, assignees, contractors and affiliates, from any and all claims, demands, causes, charges, costs, expenses, obligations, or action for damages or otherwise asserted against the Center arising out of the collection, analysis, freezing, storage, handling, thawing, transfer or release of cryopreserved materials. Patient and Partner expressly agree and acknowledge that no assurance has been given, or can be given, as to achieving the pregnancy of the Patient. Regarding this Paragraph H, Patient and Partner hereby waive and relinquish the rights and benefits afforded by Section 1542 of The Civil Code of the State of California, which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

It is specifically acknowledged and agreed by and between the parties that there is an inherent risk in the process of collection, freezing, storage and thawing of reproductive material that may render it ineffective for insemination, IVF, ICSI purposes or other reproductive procedure and that Partners have expressly agreed to assume this risk. Client understands this information and has been given the opportunity to ask questions and receive adequate additional information to make an informed decision.

It is further agreed that in the event of loss or destruction of the cryopreserved materials by any reason whatsoever, damages to the Partners as a result thereof would be highly conjectural and speculative and would be difficult to determine. Accordingly, the parties hereto agree that in the event Partner's cryopreserved materials are lost or destroyed by virtue of the breach of this agreement or negligence by Center, Partners shall be entitled to damages in the amount equal to the storage charge for the particular year in which the loss occurs, plus $100.

I. We have been informed that neither the Center nor its affiliates provide insurance coverage, compensation, or free medical care plan to compensate us if one or both of us or our embryos are harmed in any way during the course of the Cryo Program. If one or both of us or our embryos

have been harmed, one or both of us may contact the Director of the Center, who will review the matter with us.

J. We understand that we have the right to be informed whether our physician has any independent medical research or economic interests related to our participation in the IVF Program or the Cryo Program.

K. Our signatures on this form indicates that (1) we have read and understood the information provided in this form, including all terminology used in describing the Cryo Program; (2) we understand that this form cannot possibly include all the information that is relevant to the procedures in question; (3) we have had the opportunity to ask questions of our physician about the IVF Program and the Cryo Program in which we are participating and the consents of this form, and that our questions have been answered; (4) we have had sufficient amount of time to think about and to consider our decision; (5) the Cryo Program set forth above has been adequately explained to us by our physician; and (6) we have received all the information we desire concerning the procedure. We authorize and consent to participate in the Cryo Program. If we have additional questions about any information in this form, we understand that we can contact our physician.

IN WITNESS WHEREOF, the parties have entered into and executed this Directive this 16th day of November, 2013, declare to the undersigned authority that we sign and execute this Directive and that we sign willingly, that we execute it as our free and voluntary act for the purpose therein expressed, that we are 18 years of age or older, of sound mind, and under no constraint or undue influence.

ACKNOWLEDGED AND AGREED:

Patient Signature: _____

Partner Signature: _____

WITNESS ATTESTATION

I, _____, the witness, sign my name to this instrument, do hereby declare to the undersigned authority that the partners sign and execute this instrument and that they sign it willingly and that I, in the presence and hearing of the parties, hereby sign this Directive as witness to the parties' signing, and that to the best of my knowledge the parties are 18 years of age or older, of sound mind, and under no constraint or undue influence.

Witness Signature: _____

PLEASE PRINT

Name of Patient & Partner (if applicable)

Patient Street Address Apt. #

City State Zip

Home Telephone Number Patient Cell Phone Number

Patient Work Number Email Address

Partner Cell Phone Number Partner Work Number

ART Reproductive Center
450 North Roxbury Drive, Suite 520
Beverly Hills, CA 90210
Phone: 310-246-4621 Fax: 310-246-4626

INFORMED CONSENT FOR PREIMPLANTATION GENETIC SCREENING (PGS) OF ANEUPLOIDY USING ARRAY-BASED COMPARATIVE GENOMIC HYBRIDIZATION (aCGH) ANALYSIS

Purpose

The purpose of this procedure is to increase the chances of transferring into the uterus embryos that do not have recognizable chromosomal abnormalities. This falls under the general heading of pre-implantation genetic screening, or PGS.

Background

Normally, there are 23 pairs of chromosomes in each human cell, for a total of 46 chromosomes. Each of these chromosomes has a characteristic appearance and is assigned a number or letter. Twenty-three chromosomes usually come from the mother and are contained in the egg, and 23 chromosomes come from the father, derived from the sperm. Although you or your spouse are believed to be genetically normal individuals, an abnormal number of chromosomes can result spontaneously from the maturation of your egg or during the process of embryo division. Such numerical abnormalities in chromosome amounts are called aneuploidy. A common example of aneuploidy is an extra chromosome number 21 (Down Syndrome or trisomy 21).

Procedure

The entire procedure consists of four different steps, usually performed by different experts and laboratories. (i) The first part is producing embryos by In Vitro Fertilization (IVF). This part will take place at ART Reproductive Center. (ii) The second part is embryo biopsy in order to remove and analyze a cell or cells from the embryo. This is done by the ART Reproductive Center. (iii) The third part involves washing and transfer of the cell(s) into a small test tube, performed by the ART Reproductive Center. (iv) The analysis of the cells is performed by a testing facility.

Abstention from Intercourse

It is critical that patients refrain from sexual intercourse for a period of time beginning fifteen (15) days prior to the date that the patient's eggs are retrieved, and ending not before the date the patient receives conclusive results of a pregnancy test performed by the patient's physician. Abstention from intercourse is required because sperm can survive up to fifteen (15) days *in vivo*. As such, it is possible that sperm from intercourse may result in fertilization and implantation of an embryo, in addition to, or instead of, fertilization and implantation resulting from IVF. This would negate the results of PGS.

Embryo Biopsy and Cell Preparation

To test the cells, an embryologist from ART Reproductive Center makes an opening in the covering of the embryo and removes cells via aspiration with a pipette. The embryo is kept in culture and the cells that were removed are sent to the testing facility.

Patient Initials___

Cell Transport
After the cells have been biopsied and placed in test tubes, ART Reproductive Center sends the tubes to for analysis using same-day or next-morning delivery couriers.

Analysis
The genetic material within the embryo cells (DNA) is amplified using a technique called polymerase chain reaction (PCR). This amplification produces enough DNA to use a second technique, known as array comparative genomic hybridization (aCGH). Array CGH assesses DNA from each chromosome, revealing whether or not each contains the correct number of chromosomes. The cells are destroyed during this process. Therefore, they cannot be used for another purpose or returned to the embryo. This analysis requires up to twenty-four hours from receipt to complete.

Limitations
Testing for aneuploidy is unable to look at the actual structure of the chromosomes. Because of this limitation, prenatal testing after the IVF cycle with PGS is strongly advised in order to confirm the diagnosis and review the number and structure of all the chromosomes. Prenatal testing may be performed in the first trimester of pregnancy via chorionic villus sampling (CVS) or during the second trimester via amniocentesis. CVS is a procedure carried out in the late first trimester that takes cells from the placenta and analyzes them for chromosomal abnormalities. Amniocentesis is usually carried out between 15 and 20 weeks of pregnancy. A sample of the fluid that surrounds the baby is taken, and cells from the baby that are found in the fluid are analyzed for chromosomal abnormalities. PGS should not be considered a replacement for prenatal testing, as its accuracy rate is not as high. This technique is for the analysis of number variations in whole chromosomes and does not detect sub-chromosomal variations. Some levels of mosaicism cannot be detected with this technique. Mosaic embryos that have similar amounts of monosomic and trisomic cells may produce a "normal" result. The gender given for individual embryos is an estimate only and should not be considered diagnostic. Alternative methods during pregnancy may provide more accurate information concerning the gender of any fetuses resulting from these procedures.

Risks and Discomforts
In less than 15% of human eggs or embryos biopsied, the embryologists and geneticists are (1) unable to remove the cells to obtain the diagnosis, (2) unable to perform the genetic testing procedure due to technical problems, (3) obtain inconclusive or uncertain results, or (4) damage the embryo so that it cannot be used in your treatment.

Making an opening in the zona pellucida, or shell around the embryo, does not appear to inhibit embryo development and implantation. No part of the future fetus will be lacking because cell/s are removed from the three or five day embryo. The procedure may delay development by a few hours, but likely will continue its normal development. This has been observed thousands of times in humans and other animals after embryo freezing, when one or more cells normally fail to survive the thaw. Embryo biopsy is not a benign procedure. Risks include irreparable damage to the embryo, resulting in it arrest.

Patient Initial _____

It is also possible that a chromosomally normal embryo may be incorrectly identified as an affected embryo and therefore not transferred into the uterus, or that a chromosomally abnormal embryo is incorrectly identified as a normal embryo due to problems described above, and transferred into the uterus. It is not possible to guarantee that a pregnancy will occur with uterine placement of embryos that have been chromosomally screened or diagnosed for the absence of mutations. In addition, a miscarriage can occur after a woman becomes pregnant through IVF. There is a much greater chance of getting pregnant with more than one fetus through IVF compared to natural conception due to transfer of more than one embryo and due to a higher rate of identical twinning in IVF patients compared to spontaneous conceptions (1.5 to 2% vs 5.0%).

The test may find that none of the embryos are normal, and there may be no embryo transfer procedure. The likelihood that this will happen is influenced by a variety of factors, the most important of which is usually your age. Some embryos will have no diagnosis due to the loss of biopsied cells, or poor DNA quality (often found in damaged or dying cells). Embryos without a result can still be transferred, but all the possible advantages of PGS will not apply. In addition, sometimes the analysis may not be clear for one of the chromosomes being tested. This embryo could be transferred, but the possible advantages of PGS may not apply.

A third party transports the cells to a testing laboratory for analysis using same day or next morning delivery services. Weather and air travel conditions may delay the receipt of samples. Rarely, samples do not arrive to at the testing facility or are damaged during transport

Although the biopsy of embryos with PGS has been performed worldwide for approximately 15 years, the experience with this technique is considered investigational in many centers. The expense associated with embryo biopsy and genetic testing will increase the total cost of your IVF procedure.

Possible Benefits

In the majority of cases, aneuploid embryos are indistinguishable morphologically and developmentally from chromosomally normal ones. Thus, without genetic testing, an embryologist cannot differentiate normal embryos from aneuploid embryos and you could have aneuploid embryos transferred as a consequence.

Genetic testing of the preimplantation embryo can determine whether the embryo could potentially be affected by a chromosomal abnormality. Therefore, your chance of conceiving a baby with a chromosomal abnormality will be reduced by more than 90% after PGS. Your chance of conceiving an affected fetus after PGS is also reduced by 90%. However, we do strongly advise you to undergo amniocentesis or other forms of prenatal genetic diagnosis during the resulting pregnancy in order to confirm that the embryo biopsy technique was accurate and that your baby is, in fact, chromosomally or genetically normal. You may be contacted throughout the course of the pregnancy and afterwards about the outcome and would be grateful for any further information regarding the development of your child provided to us.

Patient Ini. ____

Alternatives
The alternative to utilizing this technique is to attempt to conceive a pregnancy through in vitro fertilization without genetic testing. Alternatives to PGS during pregnancy include standard prenatal testing for abnormalities (chorionic villus sampling, amniocentesis, ultrasound examination). You are not obliged to undergo PGS even if your physician recommends it. You should have prenatal testing when you become pregnant. The risks, benefits and alternatives of this testing should be discussed thoroughly with your genetic counselor, obstetrician or the person performing/ordering the tests. If you wish to be referred to a genetic counselor, please let us know. ***PGS is not a substitute for routine prenatal testing.***

Costs
Fees for PGS are in addition to the cost of the IVF cycle. The Finance Department of ART Reproductive Center will advise you of the fees. If the PGS procedure is paid for but not performed, your payment will be refunded. You are responsible for any additional medical costs incurred as a result of complications or other medical care required as a result of receiving PGS. Insurance coverage for all or any part of this total procedure may not be available, and you are personally responsible for payment of such costs, including hospital and laboratory charges, and the physician's professional fees.

Confidentiality
Confidentiality of your records will be maintained at all times. Only personnel of the embryo testing laboratory and ART Reproductive Center will have access to your records. The Department of Health of your state and the Food and Drug Administration (FDA) may also inspect the records.

Genetic Consultation Before PGS
It is recommended that you have a consultation with a genetic counselor that specializes in PGS before undergoing PGS. Talk to your IVF physician about this aspect of your care.

Specimen Retention
The cells to be tested will be destroyed during the process of the analysis. This will usually occur within 5 days of the biopsy. If the test was not performed for any unusual reason, the sample will be destroyed within 60 days of receipt, as stipulated by standard Laboratory rules. CGH testing of embryos very often requires the temporary cryopreservation (freezing) of biopsied embryos while waiting for the test results. The test results will identify both normal and abnormal embryos. The safest policy for handling your embryos is to discard the abnormal ones after we have performed embryos transfer(s) on your normal embryos.

Follow-up
Prenatal testing during pregnancy can be carried out via chorionic villus sampling (CVS) or amniocentesis. Your obstetrician, or someone he or she refers you to, can perform these tests. If prenatal diagnostic testing is not performed, cord blood at the time of the delivery should be analyzed for chromosomes. If a pregnancy loss occurs, chromosome studies should be performed on the products of conception, and reported to you IVF physician. This information will remain confidential and will be used to monitor outcomes of the PGS program.

Patient Initial

We have read the entire consent form, or it has been read to us. We understand that PGS has benefits and risks, some of which may be unknown at this time. We wish to proceed with PGS for aneuploidy using array-based CGH analysis.

We also understand that undergoing PGS for aneuploidy *does not eliminate* the need for standard prenatal testing such as chorionic villous sampling or amniocentesis. The need for these tests *remains the same* whether or not PGS for aneuploidy is performed. We understand that if we have questions about CVS or amniocentesis we may ask our obstetrician or we may request a referral to a genetic counselor.

We have been given an opportunity to ask questions about the PGS procedure and the contents of this consent form. If we think of additional questions, we may contact our physician, genetic counselor or nurse.

Print Name(s)

Patient Signature — Date: NOV 16 2013

Partner Signature — Date: 11/16/2013

Witness Signature — Date: 11/16/13

Please retain a copy of this form for your records.

Patient Initials

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

SPOUSE/PARTNER NAME: _____ DOB: _____

I hereby authorize the staff of ART SURG **to disclose my health information to the PGS testing laboratory and their staff for the purpose of conducting a PREIMPLANTATION GENETIC DIAGNOSIS (PGD) procedure and resulting pregnancy and childbirth follow-up.**

This authorization is limited in time to approximately twelve months from the date of my IVF cycle, STARTING FROM: 11/4/13 **(full date - mm/dd/yy)**

Information to be disclosed will be limited to:

- Preimplantation genetic diagnosis related information
- Previous History of Infertility and Pregnancy
- Genetic History including Karyotype and other tests
- IVF Stimulation information and progress
- Embryology Records after IVF Procedure
- Embryo Replacement and Pregnancy testing results
- Gestation and Childbirth Results
- Genetic Test Results (If applicable) of Product of Conception
- Child Information & Genetic Follow-up if Available

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the PGS testing laboratory is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purposes stated above.

I understand that I have the right to revoke this authorization at any time and this must be done in writing and presented to the **Health Information Management Department of the above-named clinic**. I understand that this revocation will not apply to the extent that the above named-clinic has already taken action in reliance on this authorization. *This authorization will automatically expire three months after childbirth unless otherwise specified.*

I understand that authorizing the disclosure of this health information is a voluntary but necessary step for the conduct of my preimplantation genetic diagnosis procedure. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that this information may be inspected by the United States Food and Drug Administration or other governmental surveillance organization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the **Health Information Management Department of the above named clinic.**

PATIENT SIGNATURE: _____ DATE: 11/4/13

SPOUSE/PARTNER SIGNATURE: _____ DATE: 11/4/13

WITNESS NAME: _____

WITNESS SIGNATURE: _____ DATE: 11/6/13

Patient Initials_____

ORIGINAL

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
Steven D. Baric SBN: 200066
Baric & Associates
2601 Main Street #560, Irvine, CA 92614
TELEPHONE NO.: 949-251-1870 FAX NO.: 949-251-1886
ATTORNEY FOR (Name):

FOR COURT USE ONLY

FILED
Superior Court of California
County of Los Angeles
AUG 29 2014
Sherri R. Carter, Executive Officer/Clerk
By M. Kurihara Deputy
Melanie Kurihara

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES
STREET ADDRESS: 1725 Main Street
MAILING ADDRESS: 1725 Main Street
CITY AND ZIP CODE: Santa Monica, 90401
BRANCH NAME: Santa Monica Courthouse

CASE NAME: John Doe v. Jane Doe, et al.

CASE NUMBER: SS 024581

JUDGE:
DEPT: RICHARD A. STONE

CIVIL CASE COVER SHEET
[X] Unlimited (Amount demanded exceeds $25,000) [ ] Limited (Amount demanded is $25,000 or less)

Complex Case Designation
[ ] Counter [ ] Joinder
Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)

Items 1–6 below must be completed (see instructions on page 2).

1. Check **one** box below for the case type that best describes this case:

Auto Tort
- [ ] Auto (22)
- [ ] Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- [ ] Asbestos (04)
- [ ] Product liability (24)
- [ ] Medical malpractice (45)
- [ ] Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- [ ] Business tort/unfair business practice (07)
- [ ] Civil rights (08)
- [ ] Defamation (13)
- [ ] Fraud (16)
- [ ] Intellectual property (19)
- [ ] Professional negligence (25)
- [ ] Other non-PI/PD/WD tort (35)

Employment
- [ ] Wrongful termination (36)
- [ ] Other employment (15)

Contract
- [ ] Breach of contract/warranty (06)
- [ ] Rule 3.740 collections (09)
- [ ] Other collections (09)
- [ ] Insurance coverage (18)
- [ ] Other contract (37)

Real Property
- [ ] Eminent domain/Inverse condemnation (14)
- [ ] Wrongful eviction (33)
- [ ] Other real property (26)

Unlawful Detainer
- [ ] Commercial (31)
- [ ] Residential (32)
- [ ] Drugs (38)

Judicial Review
- [ ] Asset forfeiture (05)
- [ ] Petition re: arbitration award (11)
- [X] Writ of mandate (02)
- [ ] Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400–3.403)
- [ ] Antitrust/Trade regulation (03)
- [ ] Construction defect (10)
- [ ] Mass tort (40)
- [ ] Securities litigation (28)
- [ ] Environmental/Toxic tort (30)
- [ ] Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- [ ] Enforcement of judgment (20)

Miscellaneous Civil Complaint
- [ ] RICO (27)
- [ ] Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- [ ] Partnership and corporate governance (21)
- [ ] Other petition *(not specified above)* (43)

2. This case [ ] is [X] is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. [ ] Large number of separately represented parties
   b. [ ] Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. [ ] Substantial amount of documentary evidence
   d. [ ] Large number of witnesses
   e. [ ] Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. [ ] Substantial postjudgment judicial supervision
3. Remedies sought *(check all that apply)*: a. [ ] monetary b. [X] nonmonetary; declaratory or injunctive relief c. [ ] punitive
4. Number of causes of action *(specify)*: 3
5. This case [ ] is [X] is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

Date: August 28, 2014

Steven D. Baric
(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE
- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on all other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

Form Adopted for Mandatory Use
Judicial Council of California
CM-010 [Rev. July 1, 2007]

CIVIL CASE COVER SHEET

Cal. Rules of Court, rules 2.30, 3.220, 3.400–3.403, 3.740;
Cal. Standards of Judicial Administration, std. 3.10
www.courtinfo.ca.gov
Westlaw Doc & Form Builder

ORIGINAL

SHORT TITLE	CASE NUMBER
John Doe v. Jane Doe, et al.	SS02458

CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION (CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)

This form is required pursuant to Local Rule 2.0 in all new civil case filings in the Los Angeles Superior Court.

Item I. Check the types of hearing and fill in the estimated length of hearing expected for this case:

JURY TRIAL? ☑ YES CLASS ACTION? ☐ YES LIMITED CASE? ☐ YES TIME ESTIMATED FOR TRIAL 5 ☐ HOURS/ ☑ DAYS

Item II. Indicate the correct district and courthouse location (4 steps – If you checked "Limited Case", skip to Item III, Pg. 4):

Step 1: After first completing the Civil Case Cover Sheet form, find the main Civil Case Cover Sheet heading for your case in the left margin below, and, to the right in Column **A**, the Civil Case Cover Sheet case type you selected.

Step 2: Check one Superior Court type of action in Column **B** below which best describes the nature of this case.

Step 3: In Column **C**, circle the reason for the court location choice that applies to the type of action you have checked. For any exception to the court location, see Local Rule 2.0.

Applicable Reasons for Choosing Courthouse Location (see Column C below)

1. Class actions must be filed in the Stanley Mosk Courthouse, central district
2. May be filed in central (other county, or no bodily injury/property damage).
3. Location where cause of action arose.
4. Location where bodily injury, death or damage occurred
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside
10. Location of Labor Commissioner Office

Step 4: Fill in the information requested on page 4 in Item III; complete Item IV. Sign the declaration.

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Auto Tort	Auto (22)	☐ A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1., 2., 4.
	Uninsured Motorist (46)	☐ A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1., 2., 4.
Other Personal Injury/ Property Damage/ Wrongful Death Tort	Asbestos (04)	☐ A6070 Asbestos Property Damage ☐ A7221 Asbestos - Personal Injury/Wrongful Death	2. 2.
	Product Liability (24)	☐ A7260 Product Liability (not asbestos or toxic/environmental)	1., 2., 3., 4., 8.
	Medical Malpractice (45)	☐ A7210 Medical Malpractice - Physicians & Surgeons ☐ A7240 Other Professional Health Care Malpractice	1., 4. 1., 4.
	Other Personal Injury Property Damage Wrongful Death (23)	☐ A7250 Premises Liability (e.g., slip and fall) ☐ A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.) ☐ A7270 Intentional Infliction of Emotional Distress ☐ A7220 Other Personal Injury/Property Damage/Wrongful Death	1., 4. 1., 4. 1., 3. 1., 4.