CONSENT TO THE STORAGE, USE AND DISPOSAL OF PBSC

This consent to the storage, use and disposal of peripheral blood stem cells (PBSC) applies to hematopoietic progenitor cells collected by apheresis (HPC-A, hereinafter "stem cells") for autologous transplantation (user recipient). Following their collection in the hospital where you are being treated, the stem cells are cryopreserved in Héma-Québec's Stem Cell Laboratory (hereinafter "Héma-Québec Laboratory") and are generally used in whole or in part in the weeks following collection.

STORAGE LIMIT

The cryopreserved stem cells that have not been used will be kept for a specified period of five (5) years. The length of time they are kept may be longer if your treating physician requests this from the Héma-Québec Laboratory.

CRYOPRESERVED STEM CELL STABILITY PROGRAM

Sample testing

During freezing of your stem cells, the Héma-Québec Laboratory freezes two (2) samples of approximately 1 ml each, in addition to the products intended for transplantation. In the days following the freezing process, one sample is thawed and tested to ensure the quality of the product. The other sample is kept in the event that the quality tests must be repeated.

Given that repeat quality testing is rarely necessary, this second sample could be used as part of the Héma-Québec Laboratory's Stability Program.

The objective of this program is to ensure that the quality of frozen stem cells remains stable over time. The program is conducted strictly for quality control purposes and is not intended for commercial use. The results may be presented during a conference or in publications. Should this occur, the results will be rendered anonymous and will not identify you. These publications are non-commercial.

You do not incur any additional risk by participating in this program. If you have more questions about the program, you can direct them to the nurse responsible for your medical file at the hospital.

You participant's file in this program is confidential and will be kept safely to ensure confidentiality, in accordance with the law. You have the right to request access to your file from Héma-Québec to verify the information that has been collected and to make corrections, as needed.

By accepting to participate in this program, you agree to allow Héma-Québec to contact you, if necessary, for the purposes of this program.

I authorize Héma-Québec to use the second sample for the Stability Program:

❒ **I consent** initials: _____

❒ **I refuse** initials: _____

TESTING OF STEM CELLS AT THE TIME OF THEIR DESTRUCTION

Héma-Québec would like to use products intended for transplantation ("cryopreserved products") directly for testing to ensure that the quality of frozen stem cells remains stable over time.

Héma-Québec will only use your cryopreserved products once they are no longer useful to you. The tests will be performed just before the products are destroyed.

This is part of the same Stability Program described above.

I authorize Héma-Québec to test my cryopreserved products, prior to their destruction, for the Stability Program:

❒ **I consent** initials: _____

❒ **I refuse** initials: _____

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RESEARCH

I authorize the hospital and Héma-Québec to contact me prior to the destruction of my cryopreserved stem cells to obtain my consent to use them as part of a research project.

❒ **I consent** initials: _____

❒ **I refuse** initials: _____

DISPOSAL OF PRODUCTS

If my treating physician deems that I am no longer eligible for autologous transplantation, I authorize the Héma-Québec Laboratory to destroy my cryopreserved stem cells, in accordance with existing standards:

❒ **I consent** initials: _____

❒ **If so, I would like you to contact me** initials: _____

In the event of death, I understand that the hospital will not communicate with my estate and will notify Héma-Québec to dispose of my cryopreserved stem cells in accordance with existing standards and the answers provided on this form.

I have had the opportunity to receive all the necessary explanations regarding the elements of this form and to ask all the questions that I had, and these were answered to my satisfaction.

I have read and understand the contents of this consent form.

_____	_____	_____
User/donor name	User/donor signature	Date (dd/mm/yyyy)
_____	_____	_____
Stem cell transplant physician name	Stem cell transplant physician signature	Date (dd/mmyyyy)
_____	_____	_____
Witness name	Witness signature	Date (dd/mm/yyyy)