Participation Agreement for the StemCure, Inc., Tissue Banking Program

• This Agreement outlines the mutual consent and obligations of the tissue banking client, hereinafter Client, and StemCure, Inc., hereinafter StemCure. Both parties agree to fully comply with the conditions of the Agreement as described below:
• StemCure is a company that performs biomedical activities related to the Cryo preservation of human tissue samples.
• The client, for the purposes of tissue banking, acknowledges that the decision to enlist StemCure to preserve his/her tissue samples was made willingly and free of any coercion, undue pressure or emotional duress.

1. The Rights and Obligations of StemCure

The rights and obligations of StemCure as they relate to the Tissue Banking Program are determined by the specificity of each particular activity: The Receiving, Processing and Cryopreservation of Tissue Samples are described in the following paragraphs:

1.1. Tissue Sample Kit. After completing the necessary forms and making the initial payment, in accordance with the Payment Agreement, Client will be sent by StemCure a standard Tissue Sample Kit, to the address specified in the completed forms. The Tissue Sample Kit contains all the tools and components necessary for the proper collection and transportation of a skin biopsy sample. Client will also receive a Participation Agreement which must be completed and signed. You will also receive a prepaid FedEx label that is to be affixed to the box containing your samples for transportation to StemCure Lab Facilities. Client will also receive an instruction sheet for the doctor who will perform the biopsy procedure, including a detailed explanation of how to perform a tissue sample swab for biopsy collection.

1.2. Medical Provider Reimbursement. After receiving and crediting your processing fee, StemCure will reimburse your doctor in the amount of $100.00 for professional services rendered in the successful collection of the tissue sample that will allow for cryogenic (deep frozen) storage by StemCure.

1.3. Laboratory Processing and Cryogenic Storage of Samples. After receiving the tissue samples, StemCure will arrange for the processing and cryogenic storage of your specimen in our laboratory. The biomedical techniques for processing and storing tissue samples are conducted at the sole discretion of StemCure. StemCure guarantees a high quality procedure that is performed in accordance with our proven laboratory methods. StemCure pledges to maintain all the necessary conditions for cryogenic tissue preservation during the term of the contract. StemCure reserves the right to test the tissue samples whenever deemed necessary, and also to reject samples for processing and/or preservation, at the company's sole discretion, if they are found not to meet our requirements. Circumstances leading to sample rejection include (but are not limited to):, (1) poor quality of the samples; (2) lack of viability and/or if (3) the analysis of a sample reveals any microbial, viral or other potentially infectious contaminant. In case any collected tissue sample will be determined by StemCure to be unfit for Cryopreservation, StemCure will notify the Client as soon as practical and the procedure of tissue sample collection may be repeated at no additional expense to the Client.

1.4. Confidentiality. All the personal information, analysis and tissue samples received by StemCure from our clients will be stored under conditions of strict confidentiality in accordance with StemCure's privacy policy and cannot be used without a client's expressed agreement, even after cancellation of the present contract, except for special circumstances stipulated by law.

1.5. StemCure Has the Right to Cancel the Contract. As outlined below, in certain cases, StemCure has the right to cancel client's contract.

A. In any case where, according to the above-mentioned criteria, due to reasons other than unsuccessful sample collection, as indicated in section 1. 3 of this agreement, StemCure conclusively determines that it cannot process and/or store your tissue samples.

B. In case a client fails to pay StemCure for services rendered within 60 days of invoice: If you fail to pay according to the "Payment Agreement" within 30 days, we will send you a reminder notice. If after receiving this reminder 30 more days pass and you fail to pay, StemCure reserves the right to cancel this agreement. In addition, Client should be responsible for any fines incurred due to unavailability or insufficiency of funds at the time client's account is charged, regardless of method of payment. Pursuant to this action Client will receive written notice by mail about the cancellation of corresponding contract due to failure of payment. Upon cancellation of Client's contract by StemCure in any of the above circumstances, StemCure will retain the right to dispose of Client's samples at its discretion. Upon cancellation of the current agreement neither Client nor StemCure will have any subsequent mutual obligations. After such a cancellation, Client cannot claim any refunds.

1.6. Scientific mission. StemCure has undertaken an important mission – the preservation of our clients' tissue samples and encompassed genetic material (DNA) at their current age, which they may then draw upon for medical purposes as they grow older. StemCure accepts client tissue from newborns (circumcision tissue is suitable) through age 70, based on our laboratory studies. At any future time, then, our clients will have access to their own tissue and the cells therein contained as they were at a younger age. It has been scientifically shown that our cells change as they age, becoming less metabolically active and gradually accumulating minor genetic mutations. This phenomenon has complicated the search for regenerative medical therapies, because the patient population seeking such treatments tends to be older and their cells tend to be less responsive. For example, the level of regenerative keratinocyte stem cells in the outer epidermal layer of our skin, or blood (hematopoietic) stem cells in our bone marrow decline gradually with age. Everyone has probably noticed how easily minor cuts and bruises heal in young children compared to older adults. Similarly, the accumulation of deleterious genetic (DNA) mutations that may eventually lead to medical problems, including cancer, increases as we age. StemCure's mission is to cryopreserve (deep freeze) biopsy tissue taken at our clients' current age, so that our clients may use it as a resource in the future as new medical advances find therapeutic uses for the cells in these tissue samples or for the DNA they contain. It has recently been reported that ordinary cells can now be converted in the laboratory to stem cells (induced pluripotent stem cells) with great regenerative potential. While not yet ready for human applications, StemCure is confident that such procedures will become more common in the future, and that our clients will have access to the best possible form of their own cells, the cells of their younger years, to take advantage of such anticipated medical advances. We are committed to helping our clients take advantage of future scientific breakthroughs and developments in regenerative medicine by safely and conveniently cryopreserving (deep freezing) suitable samples of their own tissue, harvested at a younger age.

2. The Rights and Obligations of the Client.

2.1. Examination and Completing the Documentation. Client is responsible for reading, comprehending, completing, signing, and returning all forms and registration documents provided by StemCure. By signing this agreement Client covenants and represents that he/she has been encouraged to consult his/her physician regarding the tissue sample collection procedure. Client further covenants and represents that to the best of his/her knowledge that he/she is in good health condition and has no knowledge of any health problems as of the date of the proposed procedure. The Client further understands and agrees that the services offered by StemCure are not intended and in fact are not a substitute of a medical treatment. Client is strongly encouraged to consult a physician whenever such medical treatment is necessary or advisable.

2.2. Use of Independent Professionals. To the extent reasonably necessary to enable StemCure to perform the duties under his/her agreement, StemCure may retain the services of independent physicians from time to time and/or other independent professionals that StemCure may deem proper and further to engage, or retain the services of other persons or corporations to aid or assist StemCure in the proper performance of its duties. It is expressly understood and agreed by the parties to this agreement that by retaining services of such independent parties, no agent-principal or employer-employee relationship will be intended or in fact created. Thus, StemCure shall not be liable for any services provided by independent professionals or any other third parties.

2.3. Biopsy Performance and Delivery. The client agrees to arrange for his own (without direct participation from StemCure) biopsy procedure by an independent medical provider (MD, Physician) and to inform such provider about his willingness to participate in StemCure Tissue Banking Program. Prior to the biopsy procedure, Client must take a blood test for major diseases which are indicated in Tissue Sample Kit Instructions for Medical Personnel. After successfully acquiring the tissue sample, the physician or his/her representative must properly pack the specimens in the box included and make sure the sample is mailed to StemCure in the same day within 6 hours from the moment of the biopsy procedure. The box must be brought to a FedEx Office, or call 1-800-Go-Fedex to arrange a pickup for overnight delivery.

2.4. Client's property rights. Clients, who deposit their tissues for storage and preservation and are current with all charges, have property rights to these tissues with the exception of cases where any decisions regarding the samples of minors are made by legal guardians. Upon reaching the age of 18 (majority), the minor whose tissue samples were deposited for storage and Cryopreservation receives all property rights to these tissue samples and becomes the only person to make future decisions related to the current agreement.

2.5. Payment for StemCure Services. Client is responsible for the timely payment of all services rendered by StemCure as specified in "Payment Agreement Contract."

2.6. Client Change of Address. Any changes in a client's postal address, telephone number, or electronic mail must be informed to StemCure within 30 days.

2.7. Cancellation of the Agreement. Client has the right to cancel their contract with StemCure in writing upon 60 days' notice, providing for a cancellation date and offering instructions with regard to the transfer of tissue samples. After withdrawal of the samples from cryopreservation storage as per the client's instructions, the present contract will be considered voided and StemCure will no longer bear any responsibility for the tissue samples of the client. If the client does not provide payment for the preparation and shipment of the samples**,** StemCure has the right to dispose of the samples at its discretion**.**

3. Agreement in Entirety and Release from Liability.

3.1. Entire Agreement; Governing Law. This Contract Agreement, including The Rights and Obligations of StemCure; The Rights and Obligations of the Client; Agreement in its Entirety Release from Liability; Agreement Based on the Complete Information; Healthcare Provider's Authorization for Biopsy Performance and Release From Liability and Payment Agreement represent the entire agreement between the parties. This Agreement contains the complete agreement between both parties and will supersede any and all other agreements, understandings and representations by and between the parties hereto. This agreement was written in English, which is the only language permissible to determine its interpretation. This agreement is governed by state or international laws where StemCure is registered and operates, thus excluding the effect of the conflict of laws, rules, or principles.

3.2. Force Major. If the performance of this contract becomes impossible, restricted, prevented due to any circumstances, such as any laws and ordinances or the requirement of any governmental agency or institution, or by reasons of natural calamity and/or accidents, strikes or labor conflicts, technical breakdown of the equipment, technological breakdown of process, or acts of violence and vandalism or any other action or condition beyond the control of StemCure, the company will be excused from any of the obligations under the present Contract.

3.3. Indemnification. I (Client), as a participant in the StemCure Tissue Banking Program, on behalf of myself and/or as a legal guardian of a minor, on behalf of dependent family members and heirs, hereby release and deem legally harmless StemCure and any of its affiliates, employees, contractors, subcontractors, directors, officers and agents from any litigations, claims and demands both in law and equity and agree not to institute action or suit against all these parties except if such actions result from willful or malicious conduct by StemCure. I also agree that if StemCure is found liable for willful or malicious conduct, the amount of damages that can be recovered shall be limited to the amount of money paid by me to StemCure for participation in StemCure Tissue Banking Program under the present contract.

4. Agreement Based on the Complete Information.

It is my personal decision, without any constraints, to participate in StemCure Tissue Banking Program and to provide tissues for Cryoconservation of myself and/or the minor who I represent as a legal guardian. I understand that StemCure, at its sole discretion, can decide to reject the processing and/or preservation of my tissue samples if they do not meet certain medical requirements. In this case, I cannot claim any reimbursement for the money I already paid.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES CAN BE OR HAVE BEEN MADE TO ME CONCERNING THE OUTCOMES AND/OR RESULTS OF ANY OF THE PROPOSED TREATMENTS OR PROCEDURES. IN PARTICULAR, I FULLY UNDERSTAND THAT A SUCCESSFUL BIOPSY PROCEDURE AND CRYOGENIC STORAGE OF TISSUE DO NOT GUARANTEE A POSITIVE THERAPEUTIC EFFECT IN FUTURE.

While I agree that this procedure offers an advantage by preserving my tissue at its current condition in terms of age, vitality and DNA fidelity, I understand that the only goal set by the StemCure Tissue Banking Program is to preserve this biological material at the same condition over time. Subsequently, such biological material might be used ~~in~~ for autologous (myself) cell therapy or similar approaches, as may become available at some future time for the treatment of aging and/or degenerating tissues or organs, I understand that StemCure cannot guarantee ~~it~~ availability of or access to such procedures. I also understand that payment for participation in the StemCure Tissue Banking Program is unrelated to participation in any other program, such as participation in stem cell~~s~~ or related modes of therapy.

I have carefully read, understood and accepted all the provisions of this contract that include The Rights and Obligations of StemCure; The Rights and Obligations of the Client; Agreement in Entirety and Release from Liability; Agreement Based on the Complete Information; Healthcare Provider's Authorization for Biopsy Performance and Release From Liability and Payment Agreement. I have discussed all the issues related to StemCure Tissue Banking Program with my medical care provider and my attorney. All questions I have had about the program were completely answered and I am willingly making a personal decision to participate in the StemCure Tissue Banking Program. I acknowledge that all the information furnished to me by StemCure company representatives is true and unbiased. I have signed the given agreement knowingly and voluntarily.

Client/Donor or Parent/Legal Guardian (if minor donor)*	Signature	Date

* For participants under 18 years of age, all forms in this Agreement must be signed by Parent / Legal Guardian.

5. Donor Consent Form.

If you agree participate to StemCure Tissue Banking Program please initial each box and sign this form.

1	I have read and understood everything that relates to StemCure Tissue Banking Program. My questions have been answered satisfactorily. I know how to contact the StemCure team.	initials
2	I agree participate to the StemCure Tissue Banking Program.	initials
3	I agree that my tissue samples will be extracted by biopsy procedure.	initials
4	I agree that my tissue samples will be processed in StemCure Laboratory facility.	initials
5	I give permission for StemCure to store my tissue in a StemCure Tissue Bank and in the associated with StemCure remote secure facility.	initials
6	I agree that StemCure staff can collect and securely store information regarding my health records for processing and cryopreservation of my tissue samples. I understand that the StemCure will keep my information strictly confidential in the company's secure data storage system. In addition to authorized StemCure personnel, my information will be available only to legitimate government agencies as required by law.	initials

_____	_____	_____
Client/Donor or Parent/Legal Guardian	Signature	Date

6. Healthcare Provider's Authorization for Biopsy Performance and Release from Liability.

For Adults (18 years of age and older)

I, _____, authorize my healthcare provider to perform a biopsy procedure. I understand it is my healthcare provider's final decision whether or not to perform this biopsy depending on certain medical tests. I also understand that although this biopsy is a relatively simple and straightforward procedure - a detailed description can be found in the Instructions for Medical Personnel enclosed in the Tissue Sample Kit - complications may occur after a biopsy has been performed such as rash; inflammation at the biopsy site; certain discomfort or painful sensations. In addition, as evidenced by my signature below, I release my doctor or healthcare provider as well as the institution where the biopsy was performed, its officers, directors and employees from any liabilities surrounding my biopsy procedure that might cause any damage, harm or destruction. I understand that by signing this Release of Liability, I agree to cede any legal rights, both now and in the future, to prosecute or claim any monies from my doctor; healthcare provider; hospital or medical institution for any reason or consequence surrounding this biopsy procedure.

For Minors (under 18 years of age)

I, _____, as a parent/legal guardian of _____, authorize my healthcare provider to perform a biopsy procedure. I understand it is my healthcare provider's final decision whether or not to perform this biopsy depending on certain medical tests. I also understand that although this biopsy is a relatively simple and straightforward procedure - a detailed description can be found in the Instructions for Medical Personnel enclosed in the Tissue Sample Kit - complications may occur after a biopsy has been performed such as rash; inflammation at the biopsy site; certain discomfort or painful sensations. In addition, as evidenced by my signature below, I release my doctor or healthcare provider as well as the institution where the biopsy was performed, its officers, directors and employees from any liabilities surrounding my biopsy procedure that might cause any damage, harm or destruction. I understand that by signing this Release of Liability, I agree to cede any legal rights, both now and in the future, to prosecute or claim any monies from my doctor; healthcare provider; hospital or medical institution for any reason or consequence surrounding this biopsy procedure.

_____	_____	_____
Client/Donor or Parent/Legal Guardian	Signature	Date

_____	_____
Healthcare Provider's Signature	Medical Institution Address
_____	_____
Full Name of Healthcare Provider (Please print)	City, State, Zip Code
	_____ _____
	Telephone Fax

7. Personal Information Form

For Adults

Last Name Middle Name First Name _____ Birth Date _____

Marital Status _____ E-mail Address _____

Home Address _____ Home Telephone _____

City, State, Zip Code _____

Employer _____ Work Telephone _____

Daytime Phone Number _____ Cellular Number _____

Kit Shipping Address (if different from Home Address) _____

Client/Donor Signature _____ Date _____

For Minors

Last Name Middle Name First Name _____ Birth Date _____

Name of Parent/Legal Guardian _____ Relationship to Child _____

Home Address _____ Home Telephone _____

City, State, Zip Code _____ Email Address _____

Parent/Legal Guardian's Employer _____ Work Telephone _____

Daytime Phone Number _____ Cellular Number _____

Kit Shipping Address (if different from Home Address) _____

Signature of Parent/Legal Guardian _____ Date _____

Questionnaire for donor:

Please check Yes or No	YES	NO
1. Have you had non-medical intravenous, intra-muscular or subcutaneous injections of drugs in the preceding 5 years?	❑	❑
2. Do you have hemophilia or a related clotting disorder and/or have you received human-derived clotting factor concentrates (Factor VIII or IX)?	❑	❑
3. Have you engaged in sex in exchange for money or drugs in the preceding 5 years?	❑	❑
4. Have you been an inmate of a correctional system?	❑	❑
5. Have you had sex in the preceding 12 months with any person described in 1-4 above or with a person known or suspected of having HIV infection or with a person who has had sex with another person in the preceding five years?	❑	❑
6. Have you been exposed in the preceding 12 months to known or suspected HIV, HBV and/or HCV-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane?	❑	❑
7. Are you at risk for HIV infection or are you known to be HIV-infected?	❑	❑
8. Do you have a history of autoimmune disease or malignant disease?	❑	❑
9. Have you had a transfusion of donated (i.e., not autologous) blood or blood components in the past twelve (12) months?	❑	❑
10. Do you currently have or have you in the past had infections such as Hepatitis B or C, West Nile Virus, a degenerative neurological disease such as Creutzfeldt-Jakob disease (CJD), multiple sclerosis, Alzheimer's, or encephalitis or meningitis of unknown etiology, or a history of receipt of pituitary-derived human growth hormone?	❑	❑
11. Do you have a known family history (blood relative) of Creutzfeldt-Jakob disease (CJD)?	❑	❑
12. Have you had Malaria in the past three years or traveled to a Malaria endemic area in the last six months?	❑	❑
13. Are you a native of a sub-Saharan African Country who arrived in the U.S. after 1977?	❑	❑
14. Have you had significant exposure to a substance that may be transferred in toxic doses, such as lead, mercury and gold?	❑	❑
15. Have you had a tattoo or body piercing within the previous twelve (12) months?	❑	❑
16. Have you had a confirmed positive test or treatment for Syphilis or gonorrhea within the past twelve (12) months?	❑	❑
17. Have you, within the preceding six (6) months, received a bite from an animal suspected of carrying Rabies?	❑	❑
18. Have you experienced any of the following symptoms during the last six (6) months: A. Persistent cough B. Frequent shortness of breath C. Frequent Infections	❑	❑
19. Have you ever been diagnosed with Kaposi's Sarcoma?	❑	❑

International Travel Questionnaire:

Please check Yes or No	YES	NO
1. Have you traveled outside the U.S. during the last ten (10) years? If yes, please note the countries, year(s) and length(s) of stay in the comments section below.	❑	❑
2. Between 1980 through 1996 did you spend time that adds up to 3 months or more in the U.K. (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)?	❑	❑
3. Since 1980 have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes in the U.K. (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)?	❑	❑
4. Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the U.K. from 1980 through 1996)?	❑	❑
5. Between 1980 through 1996, were you a member of the U.S. military, a civilian military employee or a dependent of a member of the U.S. military?*	❑*	❑

*** IF YOU ANSWERED YES TO QUESTION #5, PLEASE ANSWER THE FOLLOWING ADDITIONAL QUESTIONS**

• From 1980 through 1990 did you spend a total time of 6 months or more associated with a military base in Belgium, the Netherlands, U.K., or Germany?	❑	❑
• From 1980 through 1996 did you spend a total time of 6 months or more associated with a military base in Spain, Portugal, Turkey, Italy, or Greece?	❑	❑

Comments:_____
_____
_____
_____
_____

I acknowledge that all the above questions have been answered to the best of my knowledge and that the answers are complete and true. I understand that the above answers will be kept in strict confidence and may be shared only with authorized personnel from appropriate Regulatory Agencies.

_____	_____	_____
Client/Donor or Parent/Legal Guardian	Signature	Date

*Do not complete this section – **For StemCure Use Only***

Reviewed by (physician):	_____ Name	_____ Signature	_____ Date

9. Payment Agreement Contract

First Year Costs for the StemCure Tissue Banking Program Include:

1. Enrollment Fee
2. Tissue Processing Fee
3. Annual Storage for the First Year

A fee in the amount of $750 per person is payable upon your enrollment. This amount is nonrefundable and includes registration fee, tissue sample kit, medical provider reimbursement, shipping costs and tissue sample sterility test.

The remaining balance, one-time tissue processing fee and first year storage cost, is due after the successful transportation of your tissue samples as well as the processing and storage of these has been completed. This amount includes your processing fee and first year storage fee and will vary depending on the number of family members that join our program and the payment plan you choose from the list above. Please note that we offer valuable savings for every additional family member that joins the program during the 30-day family enrollment period. In addition, you can enjoy further savings by paying all Tissue Processing fees in full upon successful processing and storage initiation.

The following table lists all fees and available discounts for family enrollment.

Payment Plan for Each Family Member

Family Member:	Enrollment Fee +	Tissue Processing	
		One-Time Payment	6-Month Payment Plan
Single Member	$750	$1,000	$200 per month / $1,200 in total
Second Family Member	$750	$900	$180 per month / $1,080 in total
Third Family Member	$750	$800	$160 per month / $960 in total
Fourth or More Family Members	$750	$700	$140 per month / $840 in total
The first year of the annual storage fee is included in the charges above.			

If for any reason your tissue samples do not reach our company headquarters and/or we are unable to process and store your tissue samples according to our strict quality control standards, you may go through a second tissue donation procedure at no additional charge. The Tissue Processing fee will not be billed until all steps have been completed.

The Storage Fee for the second and subsequent years will be charged to your credit card in the amount of **$120.00** per person. It will be due one month prior to the anniversary of your contract agreement and for as long as the tissue samples remain in storage. Annual Storage Fees are guaranteed not to increase from the amount stated in the original contract.

I understand the fees as outlined in this document. My signature below certifies that I agree to be responsible for payment of these fees.

Client/Donor or Parent/Legal Guardian	Signature	Date