New Jersey Department of Health
Vital Statistics and Registry
P. O. Box 370
Trenton, NJ 08625-0370

CONSENT FOR ARTIFICIAL INSEMINATION

INSTRUCTIONS:

This form shall be completed and filed as provided by N.J.S.A. 9:17-44. The form shall be prepared and signed in duplicate. Prior to the birth of the child who was conceived as a result of artificial insemination, one copy of this form is to be filed with the Office of Vital Statistics and Registry, Artificial Insemination Processing Unit, at the address provided above.

SECTION I – TO BE COMPLETED BY BIRTH MOTHER AND BIRTH MOTHER'S SPOUSE/CIVIL UNION PARTNER

We, _____ and _____,
(First) (Middle) (Last) *(First (Middle) (Last)*
(Birth Mother) **(Birth Mother's Spouse or Civil Union Partner)**

the undersigned, are each 18 years or older.

According to New Jersey law, if, under the supervision of a licensed physician, physician assistant, or advanced practice nurse, and with the consent of her spouse, a woman is inseminated artificially with semen donated by a man not her spouse or partner, the spouse or partner is treated in law as if he were the legal parent of a child thereby conceived. Pursuant to the Civil Union Act, N.J.S.A. 37:1-28, et seq., and New Jersey's recognition of same-sex marriage, female same-sex couples who are married or in a civil union may also avail themselves of the Artificial Insemination Statute.

Our signatures below indicate that we read and understand the above information and that we consent to the performance of artificial insemination with donor semen. We acknowledge that our relationship, rights and obligations to any child born as a result of artificial insemination herein consented to shall be the same for all legal intents and purposes as if the child had been naturally and legitimately conceived by us as a married couple or civil union couple.

We understand if a child is conceived as a result of the artificial insemination consented to herein, then the licensed physician, physician assistant, or advanced practice nurse, is required by law to file a copy of this consent with the Department of Health. Pursuant to N.J.S.A. 9:17-44(a), this document is a confidential record and is not available for public inspection. This document may be subject to inspection upon an order of the court.

Name of Birth Mother *(First) (Middle) (Last)*	Name of Birth Mother's Spouse or Civil Union Partner *(First) (Middle) (Last)*
Signature of Birth Mother	Signature of Birth Mother's Spouse or Civil Union Partner
Date	Date

SECTION II – TO BE COMPLETED BY PHYSICIAN

Name of Physician, Physician Assistant, or Advanced Practice Nurse, *(First) (Middle) (Last)*	License Number
Practice Name	Telephone Number

Mailing Address (Street)	City	State	Zip Code

I certify that a child/children will be born to on the anticipated date of delivery of , that the individuals named above appeared before me and signed this form, and that the child /children were conceived as a result of artificial insemination that was performed on the following dates, in accordance with the above consent:

(List dates of insemination within one year prior to child/children's birth.)

Signature of Licensed Physician, Physician Assistant, or Advanced Practice Nurse, Named Above	Date

This consent is valid for one year or until the birth of a live child, whichever occurs first.

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