

**New Jersey Department of Health and Senior Services  
Vital Statistics and Registration  
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. Following the birth of the child who may have been conceived as a result of artificial insemination, one copy of this form is to be filed with the Office of Vital Statistics and Registration, Artificial Insemination Processing Unit, at the address provided above.*

**SECTION I – TO BE COMPLETED BY BIRTH MOTHER AND BIRTH MOTHER’S HUSBAND/CIVIL UNION PARTNER**

We, \_\_\_\_\_ (birth mother) and \_\_\_\_\_ (birth mother’s husband or civil union partner), the undersigned are each 18 years or older.

We understand that according to New Jersey law that if, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. Pursuant to the Civil Union Act, N.J.S.A. 37:1-28, et seq., civil union partners are entitled to the same legal presumption.

Our signatures below indicate that we have read and understood the above information and that we consent to the performance of artificial insemination with semen donated by a man who is not an individual listed above. 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 to all legal intents and purposes as if the child had been naturally and legitimately conceived by us as husband and wife.

We understand that if a child is born who may have been the result of the artificial insemination consented to herein, the licensed physician is required by law to file a copy of this consent with the Department of Health and Senior Services. 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 <i>(Print)</i>  <i>(First) (Middle) (Last)</i>	Name of Birth Mother’s Husband or Civil Union Partner <i>(Print)</i>  <i>(First) (Middle) (Last)</i>
Signature of Birth Mother	Signature of Birth Mother’s Husband or Civil Union Partner
Date	Date

**SECTION II – TO BE COMPLETED BY PHYSICIAN**

Name of Physician <i>(Print)</i>  <i>(First) (Middle) (Last)</i>	License Number
Practice Name	Telephone Number
Mailing Address (Street)	City, State, Zip Code

On, \_\_\_\_\_, a child/children was born to \_\_\_\_\_. On the following dates, I certify that artificial insemination was performed in accordance with the above-consent:

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

and that the individuals named above appeared before me and signed this form.

Signature of Licensed Physician Named Above	Date
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***This consent is valid for one year or until the birth of a live child, whichever occurs first.***