STEM CELL STORAGE AGREEMENT

COME NOW AGE BIOMARQ LAB, with an address of 3722 South Las Vegas Blvd., Unit 1102, Las Vegas, NV 89158, _____

_____[NAME OF PATIENT], with an address of _____, hereinafter referred to as PATIENT, _____[NAME OF DOCTOR], with an address _____ hereinafter referred to as PATIENT'S DOCTOR, and AKAN BIOSCIENCES, with an address of 20271 Goldenrod Lane, Suite 2020, Germantown, MD 20876, hereinafter referred to as PROCESSING LAB and do state and agree as follows:

I. BACKGROUND.

PATIENT wishes to save and preserve his/her Stromal Vascular Fraction (SVF) from adipose tissue (Fat) for possible future medical uses. The SVF contains stems cells and other factors that may help with regenerative treatments currently available and to be developed in the future. PATIENT has contacted PATIENT'S DOCTOR who has agreed to remove a sufficient amount of fat from PATIENT to collect such fat, and forward the fat to PROCESSING LAB to have PATIENT's SVF isolated from the fat and prepare vials with frozen SVF. PROCESSING LAB shall then properly store such vials for cryogenic storage. PATIENT shall pay a monthly storage fee to ABM to cover storage costs of PROCESSING LAB. Thereafter PATIENT shall have access to their stored SVF for PATIENT's future medical uses as permitted by the laws in the United States and other countries. At all times during the processes, the SVF vials shall remain the sole property of PATIENT.

II. PROCEDURE

1. In General. PATIENT has been fully briefed by PATIENT'S DOCTOR as the procedure for removing the fat from PATIENT, the transmission of the fat from PATIENT'S DOCTOR's office to PROCESSING LAB, and the processing of such fat by PROCESSING LAB to remove PATIENT's SVF and store in cryogenic frozen storage till future use. PATIENT is aware and has accepted the risks to his/her SVF from the procedures to remove the fat and the processing of such fat by PROCESSING LAB. PATIENT is aware and has specifically accepted that (1) his/her fat may not contain sufficient SVF; (2) that his/her SVF may be in a physical condition that would prevent their future medical use by PATIENT; (3) that the SVF may be damaged in transit from PATIENT'S DOCTOR to PROCESSING LAB; (4) that his/her SVF may be damaged and rendered unusable for his/her medical purposes by PROCESSING LAB processing procedures; (5) that his/her SVF may be damaged in transit from PROCESSING LAB to the storage facility; and that PATIENT's SVF may be damaged and rendered unusable for his/her medical uses by the effects of the cryogenic storage on them. PATIENT has been fully briefed and accepts such dangers. PATIENT states that he/she is at least eighteen (18) years of age at the time that the PATIENT signs this agreement.

2. PATIENT shall coordinate with PATIENT'S DOCTOR for the initial procedure to remove sufficient amounts of fat to create up to fifty (50) vials of SVF by PROCESSING LAB. PROCESSING LAB shall supply PATIENT'S DOCTOR with the proper containers to temporarily store and ship PATIENT's fat to PROCESSING LAB. PATIENT shall pay PATIENT'S DOCTOR all of the costs related to the following: (1) the procedure by the PATIENT'S DOCTOR to remove and transmit [as hereinafter described] PATIENT's fat; (2) the processing and storage costs of PROCESSING LAB to process PATIENT's SVF from their fat and store the SVF vials in cryogenic storage; and (3) a fee to AGE BIOMARQ LAB of $_____.

3. PROCESSING LAB shall process PATIENT's fat into SVF with a sufficient minimum of 500 cc's of lipoaspirate in order to make a "best effort" to fill up to fifty (50) vials. PROCESSING LAB shall supply the

proper containers to ship such SVF vials to the storage facility. Any vials produced in excess of fifty (50) vials shall be considered the property of Processing Lab to be used for Processing Lab's own purposes be it research, commercial, donation or otherwise.

3. a. The number of vials is not guaranteed and may vary from PATIENT to PATIENT due to quality of adipose material, chronological age of PATIENT, health condition of PATIENT and a variety of other factors.

4. The SVF vials shall be stored in cryogenic storage to be kept in liquid nitrogen at minus 193 Celsius. PROCESSING LAB shall set up an account in PATIENT's name for such vials. Patient shall be charged flat monthly fee of $_____.

5. PATIENT shall have the ability to direct PROCESSING LAB to properly transmit any number of PATIENT's vials to a third party capable to using the SVF. PATIENT shall be responsible for the payment of five hundred dollars ($500) plus all costs related to the transmission of up to 3 vials and on hundred and fifty dollars ($150) per vial thereafter.

6. Default: Patient will be in default after 30 days of non-payment of storage fee. Storage of Patient's property will be governed under Maryland Lien Law and subject to a claim of lien and may even be sold to satisfy the lien if the storage fee or other charges due remain unpaid for 60 consecutive days. A summary of Maryland Lien Law can be found here:

https://www.ssamaryland.org/News-Resources/Lien-Law

7. Force Majeure**:** In no event shall the PROCESSING LAB, ABM or Akan Biosciences be responsible or liable for any failure or delay in the performance of its obligations hereunder arising out of or caused by, directly or indirectly, forces beyond its control, including, without limitation, strikes, work stoppages, accidents, acts of war or terrorism, civil or military disturbances, nuclear or natural catastrophes or acts of God, and interruptions, loss or malfunctions of utilities, communications, computer (software and hardware) services or shipping/logistic company delays; it being understood that the PROCESSING LAB, ABM or Akan Biosciences shall use reasonable efforts which are consistent with accepted practices in the stem cell banking industry to resume performance as soon as practicable under the circumstances.

III. CONTACT INFORMATION

1. AGE BIOMARQ LAB

3722 South Las Vegas Blvd., Unit 1102, Las Vegas, NV 89158

Telephone: (847) 561-0217

E-Mail: vince@stemexcell.com

2. _____

[NAME OF PATIENT]

_____

[ADDRESS OF PATIENT]

Telephone:_____

E-Mail:_____

3. _____

[NAME OF DOCTOR]

_____

[ADDRESS OF DOCTOR]

Telephone:_____

E-Mail:_____

4. **AKAN BIOSCIENCES**

202271 Goldenrod Lane, Suite 2020, Germantown, MD 20876

Telephone: _____

E-Mail_____

[Signature Page Follows]

Dated and Effective Upon the Last Signature Date Hereinbelow

Dated this _____ day of _____, 2020

AGE BIOMARQ LAB

_____
Authorized Agent

Dated this _____ day of _____, 2020

_____[PRINTED NAME OF PATIENT]

_____
NAME OF PATIENT

Dated this _____ day of _____, 2020

_____ [PRINTED NAME OF DOCTOR]

_____
NAME OF DOCTOR

Dated this _____ day of _____, 2020

AKAN BIOSCIENCES, BY

_____[PRINTED CONTACT NAME]

_____
CONTACT NAME