

FAMILY FERTILITY CENTER
CONFIDENTIAL

SURROGATE PARENTING PROGRAM APPLICATION FORM

Please fill out as truthfully as possible and use an extra sheet of paper if necessary. Include head and shoulder color photos of you and your children with your completed application. The families often save these applications for the children conceived from the surrogate mother program. Please print as legibly as possible with dark ink. You may not have all of the information you need to complete this application today. Please keep a copy so that you may update the application as you obtain the information from memory, family members, or records; then please send us the completed form for our records.

Date of Application: ___/___/___ Application No.: _____

PERSONAL INFORMATION

Last name First name Middle Name

Maiden name: _____ Age: _____ Date of birth: _____
Marital Status: Married__ Single__ Separated__ Divorced__ Widowed__

Present Address: _____

City State Zip Code
Phone: Home (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____

Email _____

S.S. Number: ____ - ____ - ____ Driver's License No: _____ State: _____
Occupation: _____
Employer: _____
Employer's Address: _____

Spouse's name: _____ Age: _____ Date of birth: _____

If married, husband's present employer: _____

Husband's position: _____ His work# (____) _____

Husband's social security number _____

Person other than spouse to be notified in case of emergency: _____
U.S. Citizen: Yes__ No__

Date: _____ Applicant's First Name: _____ Applicant's Age _____

Medical Insurance _____ ID# _____

**FFC will require a recent copy of your medical insurance "exclusions".
Please obtain this from your provider and mail in to FFC with this
application.**

Dates of all marriages: _____

Dates of all divorces: _____

Other: _____
City, County, and State of all marriages _____

Regarding your present relationship: Years together _____ Years married _____

PERSONAL CHARACTERISTICS

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Hair: Curly__ Wavy__ Straight__

Complexion: Fair__ Medium__ Dark__

Body type/ Bone Structure: Small__ Medium__ Large__ Dress Size _____

Ethnic origin/ ancestry:

Father's side _____ Mother's side _____

Religion born into: _____ Race: _____

Education (Check One):

- ___ Completed Grade School
- ___ Completed High School
- ___ Currently in college pursuing degree in _____
- ___ Completed college degree in _____
- ___ Currently pursuing advance degree in _____
- ___ Advance degree in _____

FERTILITY HISTORY

Number of live births: _____ Dates of live births: _____
Dates and details of any pregnancy losses after 10 weeks gestation: _____

Number of children: _____

First name	Age	Sex	Birth date	Health/Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FFC will need to request your Pre-Natal and Delivery records for your last/most recent birth. Please provide the following information for that delivery:

Obstetrician Name and Practice Name _____
Telephone number _____ FAX number _____
Hospital in which you delivered _____

Present Obstetrician / Gynecologist:

Address: _____

Date of last physical exam: _____

Pap Smear? Yes _____ No _____ Date: _____ Results: _____

(FFC will require a copy of your most recent pap smear)

DO YOU AND YOUR PARTNER UNDERSTAND that, unless you had a tubal or your partner a vasectomy, you must agree to abstain from sexual activity while attempting to achieve a pregnancy for a couple? YES _____ NO _____

If there were a serious problem with the pregnancy and the prospective parents wanted to consider abortion, would you be able to or willing to abort? YES _____ NO _____

Please give a brief explanation:

Are there specific conditions under which you would not abort a pregnancy? If so, please explain:

Please check or fill out whatever applies to each pregnancy:

	1 ST	2 ND	3 RD	4 TH	5 TH	6 TH
Full term?	_____	_____	_____	_____	_____	_____
Birth weight?	_____	_____	_____	_____	_____	_____
Months to conceive?	_____	_____	_____	_____	_____	_____
Complications?	_____	_____	_____	_____	_____	_____
Cesarean?	_____	_____	_____	_____	_____	_____
Still Birth?	_____	_____	_____	_____	_____	_____

1. TELL US ABOUT ANY PREGNANCY COMPLICATIONS (e.g. premature birth, bed rest ordered by physician, gestational diabetes, toxemia, placenta previa, etc.) (Use additional paper if space as needed.) _____

2. Did you need any medical help in conceiving your children? If so, explain: _____

3. Did you take more than 6 months to conceive any of your pregnancies? If so, please comment: _____

Are your menstrual periods regular? Yes__ No__

From end of period to start of next period _____ days

How many days does your period usually last? _____ days

Have you ever been a Surrogate Mother before? Yes__ No__

If yes, when: _____ Where: _____

Have you ever been told you were infertile: Yes__ No__

If yes, when: _____ On what basis: _____

Current birth control method used: _____

If IUD, what Brand _____ Hormonal IUD? ___ Non-Hormonal? _____

If Depo Provera, when was your last injection _____

Please note: If you are on a hormonal IUD, or the Depo Provera shot you must be off that birth control and have had at least one natural menstrual cycle before you can begin treatment to be a surrogate mother.

Your diet is: Vegetarian _____ Non-Vegetarian _____
How would you describe your diet: Poor _____ Average _____ Excellent _____

How much exercise do you do: None ___ Occasionally ___ Regularly ___ Athletic ___
What type of exercise: _____

Do you currently have any allergies? Yes ___ No ___
List any medications you take regularly and what they are for: _____

If yes, are they to: Food ___ Drugs ___ Environment ___ Other ___
Please list below specific substances and reaction(s) produced:
Substance Reaction

As per above, please describe any childhood allergies you have outgrown:

Do you have normal hearing: Yes ___ No ___

Blood type: _____

HEALTH INSURANCE COVERAGE: Yes ___ No ___ Maternity Coverage? _____
Health Insurance Company: _____
Policy Number: _____
If Group Insurance, Name of Group: _____
Date Effective: _____ Waiting period, if any: _____
Monthly Premium: \$ _____ Yearly Deductible: \$ _____

Percentage of coverage: 100% _____ 80-20% _____ 70-30% _____
I have attached my insurance "exclusions" to this application; Yes _____, No _____

ACADEMIC HISTORY

Please describe academic strengths and weaknesses during school years:

Elementary School:

High School:

College:

Please describe talents, skills, and careers in your family. (Examples: music, art, athletics, medicine, law, cabinet maker)

Yourself:

Mother:

Father:

Siblings:

How many blood siblings are in your immediate family? (Including yourself): _____

Have twins or multiple births occurred in your family: Yes__ No__

If yes, what relation to you: _____

Please list below at what age members of your family died, and the cause of their death. Please be as specific as possible.

	Age (if living)	Age at time of death	Cause of death
Grandfather (paternal)	_____	_____	_____
Grandmother (paternal)	_____	_____	_____
Grandfather (maternal)	_____	_____	_____
Grandmother (maternal)	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
Sisters	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Has any member of your family, including yourself and your children, had a problem or defect at birth of any of the following body systems:

- Bones, muscles, joints, limbs Yes__ No__
- Gastrointestinal system Yes__ No__
- Nervous system, brain, spinal cord Yes__ No__
- Ears, Eyes Yes__ No__
- Blood Circulation Yes__ No__
- Respiratory system Yes__ No__
- Organ (heart, lungs, kidney, etc.) Yes__ No__
- Genital/urinary Yes__ No__
- Metabolic (hormones, enzymes, etc) Yes__ No__
- Diabetes Yes__ No__

If yes to any of the above, please explain the specific defect in each case

Birth defect	Who	How did it happen	Circumstances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any brothers or sisters who died in infancy or childhood? Yes__ No__

If yes, please explain what was the cause: _____

Are there any known genetic diseases or conditions that run in your family? Yes__ No__

If yes, please explain what they are: _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious) Yes__ No__

If yes, please explain them:

ALCOHOL USE

Please indicate current alcohol use by each family member:

DRINKS PER WEEK

	None	1-2	3-5	6-10	Over 10
Yourself					
Grandfather (paternal)					
Grandmother (paternal)					
Grandfather (maternal)					
Grandmother (maternal)					
Father					
Mother					
Brothers					
1.					
2.					
3.					
Sisters					
1.					
2.					
3.					

CONDITION

Look through the following list of medical problems and indicate which ones you or one of your relatives has had. Please consider each condition carefully for each family member. Check (√) all that apply.

Heart	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Stroke							
Heart Attack							
Heart disease							
From birth							
Other							
Hardening of arteries							
High Blood Pressure							

If you answered yes to any of the above conditions, please explain:

Blood	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Anemia							
Sickle cell							
Hemophilia							
Leukemia							
Immune deficiency							
Other							

If you answered yes to any of the above conditions, please explain:

Urinary	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Kidney Disease							
Rectal Disorder							
Other							

If you answered yes to any of the above conditions, please explain:

Gastro intestinal	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Ulcer							
Gall Stones							
Hepatitis A							
Hepatitis B							
Liver Disease							
Colon Cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							
Other							

If you answered yes to any of the above conditions, please explain:

Respiratory	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung Cancer							
Pneumonia							
Other							

If you answered yes to any of the above conditions, please explain:

Mental Health	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Schizophrenia							
Manic Depressive							
Depression							
Anxiety							
Learning disabilities							

If you answered yes to any of the above conditions, please explain:

Genital/ Reproductive	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Undescended testicle							
Hypospadiasis							
Prostate cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix							
Cancer of ovaries							

If you answered yes to any of the above conditions, please explain:

Muscles, Bones and Joints	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Muscular dystrophy							
Chronic muscle disease							
Lupus							
Deformity of spine							
Dwarfism							
Low back pain							
Gout							
Osteoporosis							

If you answered yes to any of the above conditions, please explain:

Skin	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Acne							
Eczema							
Skin Cancer							
Pigmentation Disorders							
Other							

If you answered yes to any of the above conditions, please explain:

Sight, Sound, and Smell	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color Blindness							
Glaucoma							
Deviated septum							
Other disease							

If you answered yes to any of the above conditions, please explain:

Other	You	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousins
Alcoholism							
Drug Abuse							
Breast Cancer							
Any other Cancer							
Any other condition							

If you answered yes to any of the above conditions, please explain:

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality and character:

If you could pass on a message to the recipient(s), what would the message be:

What kind of support do you expect or foresee from the following people in your life?

Your Husband/Boyfriend? _____

Your own parents? _____

Friends/Co-Workers? _____

Would you like to have the couple in the delivery room? _____

What reassurance can we give the prospective Parents that you will not change your mind about relinquishing the child? _____

Why do you want to be a surrogate mother? _____

I, the undersigned, do hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

Signature: _____ Date: _____

How did you become aware of the **Family Fertility Center**?

- ___ Newspaper advertisement
- ___ Newspaper/magazine article
- ___ Friend/acquaintance
- ___ Other _____

**** PLEASE ATTACH A RECENT PHOTOGRAPH OF ****
****YOURSELF AND ONE OF YOUR CHILDREN/FAMILY****

- b. Would you agree to amniocentesis for diagnostic purposes if the couple requested this?
 - c. Would you abort if the couple requested and Downs Syndrome was diagnosed?
 - d. What reasons would you consider not acceptable for termination at couple's request?
5. What kind of contact with prospective parent(s) would you want
- a. During pregnancy
 - b. During delivery and hospital stay
 - c. After delivery
6. If you are an IVF surrogate, who will give your daily progesterone injections?
7. In which hospital would you want your delivery? Which doctor do you prefer?

Date: _____ Applicant's First Name: _____ Applicant's Age _____

Is there any history of fertility problems in your family? (Difficulty conceiving or miscarriages): Yes__ No__

If yes, explain: _____

Did your parents have difficulty conceiving: Yes__ No__

Do any of your siblings have fertility problems: Yes__ No__

Do any of your family members have fertility problems: Yes__ No__

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings? Yes__ No__

If yes, explain: _____

Please explain any miscarriages or abortions you have had. Include dates and how far along you were. _____

PERSONAL HEALTH HISTORY

Do you smoke? Yes__ No__ If yes, how much daily? _____

Does your partner smoke? Yes__ No__ If yes, how much daily? _____

Do you drink alcohol? Yes__ No__ If yes, how many? _____

Have you ever abused alcohol? Yes__ No__
If yes, when and how much? _____

Are you using marijuana now? Yes__ No__ If yes, how often? _____

Have you used illegal or un-prescribed drugs (with in the last three years)? Yes__ No__

If yes, what drugs and how often: _____

Have you ever had surgery? Yes__ No__

If yes, please explain: _____

Have you ever had hospitalization not already mentioned? Yes__ No__

If yes, please explain: _____

Have you ever had major radiation or X-ray exposure? Yes__ No__

If yes, please explain: _____

Did you ever live overseas? If so, how long and why? _____

Have you ever had any problems with the law? Yes__ No__

Please list any arrests, convictions, sentences, etc: _____

Have you ever been treated for syphilis: Yes__ No__ If yes, when: _____

How many times? _____ When was the last time? _____

Have you ever been treated for gonorrhea: Yes__ No__ If yes, when: _____

How many times? _____ When was the last time? _____

Have you or any of your sexual partners had:

			<i>Myself</i>	<i>Partner</i>	<i>When</i>
NSU (non-specific urethritis)	Yes__	No__	__	__	_____
Chlamydia	Yes__	No__	__	__	_____
Veneral warts	Yes__	No__	__	__	_____
Herpes	Yes__	No__	__	__	_____
Other sexually transmissible diseases	Yes__	No__	__	__	_____

Have you had any therapy with a psychiatrist or any other mental health professional?

Yes__ No__ If yes, when and why: _____

Have you ever had psychiatric hospitalization: Yes__ No__

If yes, please be as specific as possible: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

(Civil Code section 56.10)

TO: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH CARE PROFESSIONAL:

YOU ARE HEREBY AUTHORIZED to release to **FAMILY FERTILITY CENTER** any and all medical, psychological, psychiatric, or health information pertaining to me, which is now or in the future may be in your possession or under your control.

FAMILY FERTILITY CENTER is expressly authorized hereby to copy, or receive copies of, any records or documents pertaining to me or the information specified above, and to distribute said copies to _____ (Prospective Parents) or to any other Prospective Parents and to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in, or in connection with, the surrogate mother program agreement I entered into with the Prospective Parents identified above or with other Prospective Parents.

This authorization shall remain valid for two years from the date hereof.
I have been advised of my right to receive a copy of this Authorization.
I have received a copy of this Authorization Yes__ No__

Dated: _____

Surrogate Mother

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Family Fertility Center to disclose the information contained in this Surrogate Application to anyone interested in reviewing my application to assist them in selecting a Surrogate, and for review by appropriate medical and psychological professionals and their staffs. I understand, and expressly condition this authorization upon such understanding, that my last name will not be disclosed to any such interested persons or professionals.

I have received a copy of this Authorization.

Dated: _____
_____ Surrogate Mother

I am _____, the husband/partner of _____.

I cannot attend the intake interview that you have scheduled for my wife/partner on _____.

___ I am supportive of my wife's/partner's decision to be a surrogate to help an infertile couple have a child.

___ I am not supportive of my wife's/partner's decision to be a surrogate to help an infertile couple have a child.

The reasons for my decision are as follows (in no order of importance):

1.

2.

3.

4.

5.

(Continue on back if necessary)

Date

Signature

APPLICANT REFERENCES

When calling references we simply state that you are applying for a position working with the public. We do not mention anything related to Surrogate Mother or the Family Fertility Center.

Please provide the names of 3 (three) acquaintances, friends, or co-workers, that have known you for more than 5 years; DO NOT include relatives or in-laws. If you have an employment history, please include one person who was your supervisor.

Applicant's Name _____ Date: _____

Name: _____ Relationship: _____

Phone No: (____) ____ - ____

Name: _____ Relationship: _____

Phone No: (____) ____ - ____

Name: _____ Relationship: _____

Phone No: (____) ____ - ____