GLOBAL FERTILITY SERVICES | 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, husbands 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#
_____

GFS will require a recent copy of your medical insurance "exclusions". Please obtain this from your provider and mail in to GFS 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 _____

GLOBAL FERTILITY SERVICES | CONFIDENTIAL

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
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

GFS will need to request your Pre-Natal and Delivery records for all pregnancies. 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:

_____

_____

Phone and fax numbers

Date of last physical exam: _____

Pap Smear? Yes____ No_____ Date: _____ Results: _____

(GFS 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:

	1ST	2ND	3RD	4TH	5TH	6TH	
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 you 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:

_____
_____
_____
_____

Grandparents:_____
_____
_____
_____
_____

Did you have any learning disabilities?

_____
_____
_____
_____

Please describe your childhood:

_____
_____
_____
_____

Imagine yourself five years from today watching from a distance the child born, playing in a playground. What do you imagine yourself feeling and thinking?

_____
_____

PERSONAL HEALTH: WORK HISTORY/EXPOSURE

What is your current or most recent occupation:_____
Please list all jobs you have had in the past five years and your possible exposure to chemicals, drugs, and gases. Please consider carefully.

Jobs/Duties Year Began Year Ended Exposed to which drugs, chemicals, gases

_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

In the past six months have you been exposed to any of the following in your living environment, or while involved in hobbies or extra curricular activities? If yes, please check the appropriate item below and give dates and how often you have been exposed. Please consider each carefully.

Exposed to: WHEN HOW OFTEN
__ Toxic Chemicals _____
_____

__ Sprays _____
_____
__ Fumes/Exhaust _____
_____
__ Radiation _____
_____
__ Flea powders/sprays _____
_____
__ Lead/ Lead products _____
_____
__ Asbestos / products _____
_____

FAMILY HEALTH HISTORY

Please describe your family members by the following physical characteristics:

	Eye color	Hair Color	Complexion	Height	Body type	Vision
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Paternal: Grandfather	_____	_____	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____	_____	_____
Maternal: Grandfather	_____	_____	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____	_____	_____

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 **Global Fertility Services?**

___ Newspaper advertisement
___ Newspaper/magazine article
___ Friend/acquaintance
___ Other_____

**** PLEASE ATTACH A RECENT PHOTOGRAPH OF ****

****YOURSELF AND ONE OF YOUR CHILDREN/FAMILY****

Name_____ Date_____

GLOBAL FERTILITY SERVICES
CONFIDENTIAL

SURROGATE QUESTIONNAIRE

Please be as honest and complete as possible when answering these questions.

1. What's important to you in a prospective parent(s) (e.g. income, education, childless or already have children?)

2. Who would you not work with and why (ie: are you open to working with a single person (male or female), a person/or couple that lives in another country, and/or a gay or lesbian couple)?

3. Please **call GFS @ 800 939-6886** when you are ready to fill in this section. The information here is part of your contract. Once completed, it cannot be renegotiated. Couples will select you on the basis of your information.
    a. If bed rest required, support needed

    b. Incidental costs you anticipate

4. Ethical Questions – Please describe your feelings about the following issues:

a. Would you reduce triplets to twins?

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:

			Myself	*Partner*	*When*
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 **GLOBAL FERTILITY SERVICES** 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.

GLOBAL FERTILITY SERVICES 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 Global Fertility Services 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 Global Fertility Services.

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: (__ __ __) __ __ __ - __ __ __ __