Surrogacy International, Inc.

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DONOR APPLICATION

CONTACT INFORMATION:

Donor Full Name: _____ DOB: _____

Address: _____

_____

Phone 1: _____ Phone 2: _____

Email address: _____

How would you like us to contact you? ☐ Email ☐ Phone

PERSONAL INFORMATION:

Are you a U.S. citizen or a permanent resident? ☐ Yes ☐ No

Drivers' License #: _____ State drivers' license was issued: _____

Have you ever lived or traveled out of the United States? ☐ Yes ☐ No

If so, when, where did you go and how long were you there? _____

_____

Current relationship status: ☐ Single ☐ Married ☐ Partnership ☐ Other: _____

Spouse/Partner Name: _____ DOB: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Natural hair color: _____ Eye Color: _____

Race(s): _____

[If possible, please include 2-3 photographs of yourself as a child with this application.]

Are you of Native American or Indian blood ancestry? ☐ Yes ☐ No

If yes, name of tribe: _____

Are you of Jewish blood ancestry? ☐ Yes ☐ No Are you of Asian ancestry? ☐ Yes ☐ No

Occupation: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Other: _____

Employer / University (if applicable): _____

What is the highest level of education you have completed? ☐ High School ☐ Some college ☐ College (BS/BA)

☐ Post-graduate ☐ Other: _____ Degree: _____

Do you currently have health insurance: ☐ Yes ☐ No If yes, Type of Insurance: _____

Are you currently on any government assistance: ☐ Medical ☐ Cash Aid ☐ Food stamps ☐ Other _____

Are you willing to donate for a single man, single woman, or same sex couple? (A negative answer will not disqualify you from being selected as a donor?) ☐ Yes ☐ No

Do you prefer to know the recipient of the donated eggs? ☐ Yes ☐ No ☐ Indifferent

BASIC HEALTH INFORMATION:

Have you ever donated eggs before? ☐ Yes ☐ No Number of times? _____ Number of eggs donated? _____

Have you worked with an agency before? ☐ Yes ☐ No

If yes, name of agency: _____

Do you have any known medical/psychological condition(s) that may interfere with donation? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No

Do you use any non-prescribed drugs? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week on average? _____

Are you currently on birth control? ☐ Yes ☐ No If yes, name of birth control? _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list all medications: _____

_____

Do you have a menstrual cycle each month? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? _____

Do you have both ovaries? ☐ Yes ☐ No

Have you ever had plastic surgery? ☐ Yes ☐ No If yes, describe the alteration: _____

Have you ever received anesthesia? ☐ Yes ☐ No If yes, what for? _____

Have you ever had any problems related to anesthesia? ☐ Yes ☐ No If yes, explain: _____

Do you know your blood type and Rh Factor? ☐ Yes ☐ No If yes, Blood type: _____ Rh Factor: _____

Do you or any immediate family members have any known genetic conditions that may interfere with donating or the health of a child? ☐ Yes ☐ No If yes, explain: _____

_____

Have you had any tattoos or body piercings within the last 12 months? ☐ Yes ☐ No

ADDITIONAL INFORMATION:

Very briefly, tell us why do you want to be an egg donor? _____

_____

_____

_____

How did you hear about us (please be specific)? _____