EGG DONOR APPLICATION

Full Name (include maiden name if applicable): ________________________________

Address: ____

Social Security Number: ____

Birth Date: ________________ Birth Place: ________________________
(City) (State)

Telephone number (include area code):

Daytime: ________________________
Evening: ________________________
Cell: ___________________________

Do you have voicemail, answering machine, or a place where we can leave messages?

□Yes □No

If so, where?____

Best time to contact you: ____

Email Address: ____

Current Occupation: ____

How long have you been employed in this occupation? ______________________

Marital Status (check one):

____Single ____Married ____Separated ____Divorced ____Partner (boyfriend/girlfriend)
____Widow

Spouse's or Partner's Full Name (if applicable): ____________________________

In case of an emergency, whom should we contact? __________________________

What is his/her relationship to you? ____________________________________

Emergency Contact's Phone Number(s):__________________________________

Do you drive and have a valid driver's license? ______________

Do you own a car? __________

Are you willing to travel for an egg donation? ________________________

Are you willing to fly on an airplane for an egg donation? ___________________________

Do you have medical insurance? ____

What is your religion and are you currently practicing this religion? ____________________

Are you adopted? __________

If so, do you have information about your biological family? __________________________

Do you have any legal cases pending against you? If so, please explain. _______________________
____

Have you ever filed bankruptcy? __________________________

Have you been convicted of a crime? If so, please explain. _________________________________
____

Do you prefer to do an anonymous donation? ______________________

Do you prefer, or are you willing, to talk to or meet the intended parents? Please elaborate:
____
____

Are you willing to donate to same-sex intended parents? _________________________________

Are you willing to donate to international intended parents? ______________________________

Are you willing to donate to a single intended parent? ___________________________________

Are there any types of intended parents who you will not donate to? If so, please elaborate:
____
____

If you are an experienced Egg Donor, please complete the following section:

Date	**Clinic/Doctor**	**# Eggs Retrieved**	**# Embryos**	**Pregnancy?**	**Type of Pregnancy (single, twins, etc.)**

Have you told your family and friends about your decision to donate? If so, who have you told and are they supportive of your decision? ____

Do you currently smoke? __________________________

Have you ever smoked in the past? If so, list approximately dates during which you smoked and how frequently you smoked (e.g. number of cigarettes or packs per day or week): _________________

Have you had and/or been treated for a substance/alcohol abuse/addiction problem? ____________

Do you use illegal drugs? _________________

Are you currently taking birth control pills? If so, what type? __________________________

Other than birth control pills, are you currently taking any prescription medication? If so, please elaborate (name of medication, dosage, duration of use, purpose, etc.): ____________________

____

Do you take any herbal remedies or supplemental vitamins on a continual basis? If so, please describe.

____

Please list any surgeries or hospitalizations and dates they occurred? _____________________

____

Have you ever been under the treatment of a psychiatrist or psychologist for a psychological disorder? If so, please list approximately dates of treatment, treatment duration and reason(s) for treatment.

____

____

Requested compensation: _________________________

Is this compensation request negotiable? _______________

What is the *least* amount of compensation you will consider accepting for an egg donation?

____

When will you be available for an egg donation? ____________________________

Do you have any scheduling restrictions? (Please remember to keep us updated of any schedule restrictions as they arise and notify us if you have been matched for a donation through any other means):

____

Are you currently listed with other egg donation clinics or agencies? __________________

If so, which ones? (Please remember to notify us if you have been matched for a donation through any other agency/clinic.

____

____

Would you be interested in being a surrogate or gestational carrier? ______________________

Have you traveled or resided outside of the United States for any period of time longer than 3 months at a time during your lifetime? If so, when and where? Please be as detailed as possible.

____

____

Do you plan to travel outside of the United States in the future? If so, please describe when, where and for how long.

____

____

Have you had any tattoos, piercing, blood transfusion etc in the last 12 months? If so, when? (Note: donors cannot have received any tattoos, body piercing, or blood transfusion during the 12 months prior to initiating screening for an egg donation).

____

____

Does your sexual partner/husband understand that s/he may also be required to undergo screening (blood tests) to make sure he is free of sexually transmitted infections, HIV, and other communicable diseases? Your partner/husband understands that s/he may be required to travel WITH you to the clinic for a day?

____

Have you ever had a blood transfusion? If so, when and why?

____

Have you ever received growth hormone made from human pituitary glands?

____

Have you ever had a dura mater transplant? ______________________________________

Have any of your blood relatives ever had Creutzfeldt-Jakob disease? ____________________

Personal and Family Demographics

Ethnicity *(please be as specific as possible):* ____________________ Race: _______________

Blood type & RH Factor *(if unknown, please consult with your primary care physician to obtain this information or plan to obtain a blood type test, as it is important to some prospective parents):*

____

Height: ____________________ Weight: ______________________

Natural hair color: ____________ Eye color: _____________________

Hair texture (check one):

__straight ____curly ____thick ____thin

Skin tone (check one):

____fair ____medium ____dark ____olive ____other

How would you describe your ability to tan? (*tan easily, tend to sunburn, etc*)___________________

Build (check one): ___ petite ____medium ____large

Have you ever worn braces? If so, during what age(s)? ____________________________________

Shoe Size: _________________

Dimensions (Bust Measurements/Waist/Hips):

____

Biological Mother

Ethnicity *(please be as specific as possible):* ____________________ Race: _______________

Height: ____________________ Weight: ______________________

Natural hair color: ____________ Eye color: _____________________

Hair texture (check one):

____straight ____curly ____thick ____thin

Skin Tone (check one):

___fair ___ medium ___olive ___dark ___other

How would you describe her ability to tan? (*tan easily, tend to sunburn, etc*) ___________________

Health Condition:____

Personality Description:

____

____

Occupation: ____

College Degrees (if any): ____

Talents/Hobbies: ____

Number of Brothers: _______________

Number of Sisters:_______________

Biological Father

Ethnicity *(please be as specific as possible)*: ____________________ Race: _______________

Height: ____________________ Weight: ______________________

Natural hair color: _____________ Eye color: _____________________

Hair texture (check one – place check to the LEFT of your choice):

____straight ____curly ____thick ____thin

Skin Tone (check one - place check to the LEFT of your choice)

___fair ___ medium ___olive ___dark ___other

How would you describe her ability to tan? (*tan easily, tend to sunburn, etc*) ___________________

Health Condition:____

Personality Description:

____

____

Occupation: ____

College Degrees (if any): ____

Talents/Hobbies: ____

Number of Brothers: _______________

Number of Sisters:_______________

NOTE: Please copy and paste additional sections if you have more than one sibling. Please also note if the sibling is a half-sibling. Please note that we do not require information regarding non-biological step or adopted siblings.

Biological Sibling of Donor

Gender: _______________ Age: _________ Height: ___________ Weight:_________

Natural hair color: _____________ Eye color: ______________________

Hair texture (check one):

____straight ____curly ____thick ____thin

Skin Tone (check):

___fair ___ medium ___olive ___dark ___other

How would you describe her ability to tan? (*tan easily, tend to sunburn, etc*) ____________________

Health Condition:____

Personality Description:

____

____

Occupation: ____

College Degrees (if any): ____

Talents/Hobbies: ____

Age and sex of children, if any:

____

Biological Sibling of Donor

Gender: _______________ Age: _________ Height: ___________ Weight:_________

Natural hair color: _____________ Eye color: ______________________

Hair texture (check one):

____straight ____curly ____thick ____thin

Skin Tone (check one):

___fair ___ medium ___olive ___dark ___other

How would you describe her ability to tan? (*tan easily, tend to sunburn, etc*) ____________________

Health Condition:____

Personality Description:
____
____

Occupation: ____

College Degrees (if any): ____

Talents/Hobbies: ____

Age and sex of children, if any:
____

Biological Grandparents of Donor
Please complete the following chart with the requested information regarding your biological grandparents:

	Hair Color	**Eye Color**	**Age**	**Deceased?**
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

What degree(s) do you currently hold (e.g., high school diploma, Bachelor's, Master's, Ph.D., M.D., J.D., R.N., etc.): ____

High School GPA: ______________________

Year of high school graduation: _______________

Did you receive any awards, honors, scholarships, etc. while in high school? If so, please elaborate:
____
____

Were you involved in any extra-curricular activities in high school? If so, please elaborate.
____
____

Which subjects did you enjoy most in high school? ________________________________

SAT Scores: Quantitative: ________ Verbal: _________
GRE Scores: Quantitative: ________ Verbal: _________ Analytical: _________
LSAT Score: _________________
ACT Score: __________________
IQ Score (if known): ____________

Name and dates of undergraduate college(s) attended (if any):

____

Undergraduate G.P.A.: ____________________

Major Area(s) of Study: ____________________________

What year did you graduate or what year do you expect to graduate from your undergraduate program? If you started the program, but did not and will not complete it, please be sure to indicate this.

____

____

Did you receive any awards, honors, scholarships, etc. in your undergraduate program? If so, please elaborate:

____

____

Were you involved in any extra-curricular activities in your undergraduate program? If so, please elaborate.

____

____

Which subjects did you enjoy most in college? ____________________________________

Name and dates of *graduate* programs(s)/law school/medical school attended (if any):

____

____

Graduate Program G.P.A.: ______________________

Major Area(s) of Study: ____

What year did you graduate or what year do you expect to graduate from your graduate program? If you started the program, but did not and will not complete it, please be sure to indicate this.

____

____

Did you receive any awards, honors, scholarships, etc. in your graduate program? If so, please elaborate:

____

____

Were you involved in any extra-curricular activities in your graduate program? If so, please elaborate.

____

Medical Screening

Place a check or "X" next to any medical condition applicable to you or your family members. For any conditions endorsed for your grandparents, aunts, uncles, or cousins, please indicate whether they are from the maternal or paternal side of your family.

	You	Mother	Father	Sibling	Grandmother	Grandfather	Aunt/Uncle	Cousin
Wears Corrective Lenses								
Stroke								
Heart Attack								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Anemia								
Hemophilia or other bleeding disorder								
Leukemia								
HIV								
Lymphoma								
Environmental Allergies								
Other Allergies								
Asthma								
Emphysema								
Tuberculosis								
Lung Cancer								
Pneumonia								
Stomach Ulcer								
Gall Stones								
Hepatitis A, B, C (please specify)								
Cirrhosis								
Colon Cancer								
Ulcerative Colitis								
Crohn's Disease								
Cystic Fibrosis								
Pyloric Stenosis								
Rectal Disorder								
Diabetes Mellitus Type 1								
Diabetes Mellitus Type 2								
Thyroid Cancer								
Thyroid Disease								
Goiter								
Adrenal Dysfunction/Disorder								
Kidney Disease								
Other Urinary Tract Disease								
Prostate Cancer								
Testicular Cancer								
Uterine Fibroids								
Ovarian Cysts								
2 or more miscarriages								

	You	Mother	Father	Sibling	Grandmother	Grandfather	Aunt/Uncle	Cousin
Cancer of cervix, ovaries, or uterus								
Stillborn								
Death of Newborn Baby								
Neonatal Jaundice								
Migraines								
Mental Retardation								
Down Syndrome								
Multiple Sclerosis								
Cerebral Palsy								
Epilepsy/Seizures								
Hydrocephalus								
Spina Bifida/Neural Tube Defect								
Huntington's Disease								
Alzheimer's Disease								
Parkinson's Disease								
Wilson's Disease								
Gaucher's Disease								
Canavan's Disease								
OCD, ADHD, ADD								
Schizophrenia/Psychotic Disorder								
Major Depressive Disorder								
Bipolar Disorder								
Alcoholism								
Drug abuse/addiction								
Male Pattern Baldness								
Osteoporosis								
Dwarfism								
Arthritis								
Gout								
Myasthenia Gravis								
Deafness before age 60								
Blindness								
Color Blindness								
Eczema								
Skin Cancer								
Pigmentation Disorder								
Neurofibromatosis								
Cleft Lip/ Cleft Palate								
Club Foot								
Scoliosis								
Tourrette's Syndrome								
Paraplegia								
Muscular Dystrophy								
Lupus								
Turner Syndrome								
Kleinfelter Syndrome								
Breast Cancer								
Cancer								
Other:								

IMPORTANT: Please elaborate on any medical conditions endorsed above. For any major medical conditions/illnesses endorsed, list age of onset, treatment required, the extent to which illness has been debilitating, recovery information, etc. Also, for all grandparents, aunts, uncles, and cousins that had/has an illness, list whether they are from the maternal or paternal side of your family:

____

____

____

____

Are there any other medical conditions in your family not addressed above that your intended parents should be aware of? ____

Have you ever been screened to determine whether you are a carrier of a cystic fibrosis gene mutation?

____

Are you or any of your family members known carriers of a cystic fibrosis gene mutation?

____

Have you ever been tested for the Tay-Sachs gene mutation?

____

Are you or any of your family members known carriers of a Tay-Sachs gene mutation?

____

Have you ever been tested to determine whether you a carrier of sickle cell anemia?

____

Are you or any of your family members known carriers of sickle cell anemia?

____

Please list the deaths of any parents, siblings, aunts, uncles, and grandparents. Include the relationship of the individual to you (also specify whether paternal or maternal relative), age of death, and cause of death:

____

____

Do you exercise? If so, what type of exercise and how often?

____

Sexual/Reproductive History:

Describe the typical length of your menstrual cycle (e.g., normal 28 days cycle? Shorter? Longer?):

____

How long does your menstrual cycle flow typically last?

____

Do you experience PMS-related symptoms before or during your period (e.g., cramping, bloated, etc.)? If so, please elaborate:

____

____

Have you or any of your family members been diagnosed with endometriosis?

____

Have you ever tested positive for a Sexually Transmitted Infection (STI)? If so, when and how was it treated?

____

Have you ever had an abnormal pap smear? If so, when and how was it treated?

____

Have you ever been pregnant?

____

Do you have children? Please elaborate (children's gender and month/year of birth):

____

____

____

Have you ever experienced any pregnancy complications such as, pre-term labor, gestational diabetes, placenta previa, emergency cesarean section, preeclampsia, etc?

____

Have you ever had an abortion? If so, please list dates:

____

Has anyone in your family given birth to fraternal or identical twins? If so, please elaborate:

____

Personality Questions

Why have you decided to undergo egg donation?

____

____

Describe your personality as an adult:

____

____

Describe your personality as an adolescent:

____

____

Describe your personality as a child:

____

____

What is your "philosophy of life"?

____

____

What are your personal goals? Have you achieved any of these goals?

____

____

What personal achievement are you most proud of?

____

____

What is your:

Favorite color? ____

Favorite type of food? ____

Favorite movie? ____

Favorite type of music? ____

Favorite book? ____

What are your special interests/hobbies/talents? ___________________________

____

Would you be willing to meet a child conceived as a result of your donation? Please elaborate:

____

____

Is there anything else you would like to tell intended parents interested in working with you?

____

____

____