GESTATIONAL CARRIER APPLICATION

1. Full name: _____

2. Maiden name (if applicable): _____

3. Social Security Number: _____

4. Address:_____
(Including: City/State/Zip/County)

5. How long have you lived at your current address? _____

6. If less than two years, please list prior addresses for the last two years.

_____

_____

Please list all the states you have lived in for the past 10 years:

_____

7. Telephone number (include area code):
Daytime: _____
Evening: _____
Cell: _____

8. Do you have voicemail, answering machine, or a place where we can leave messages?
___Yes ___No
If so, where?_____
Email address: _____
Best time to contact you: _____

1. Name you would like to be called: _____

2. Age: _____

3. Date of birth: _____

4. Height: _____

5. Weight: _____

6. Race/ethnic background: ___White ___African American ___Asian ___Latin American ___Other (Please specify):_____

7. U.S. Citizen: ___Yes ___No

8. Check one: ___Married ___Divorced ___Widowed ___Separated ___Engaged ___Single

9. How long have you been married? _____

10. Have you ever experienced any marital problems? ___Yes ___No If yes, explain:

    _____

11. If not married, first name of partner: _____

    Do you live together: ___Yes ___No If yes, how long? _____

12. Spouse's/Partner's Name: _____ Age: _____ D.O.B. :_____

13. Sex and Number of children: Males _____ Ages:_____ Females:_____ Ages:_____

14. Are children biologically related to your husband/partner? ___Yes ___No

15. Would you like to have any more children of your own in the future? ___Yes ___No

16. If divorced, when did it occur? ___Yes ___No

17. What was the cause of the breakup? _____

18. Have you remarried? ___Yes ___No

19. How long ago? _____

20. Religious background: _____

Practicing: ___Yes ___No

21. Preference for the religious background of the intended parents:

___Yes_____ ___No

22. Would you be willing to work with:

Same sex couple:	__Yes __No
Single male:	__Yes __No
Single female:	__Yes __No
Couple using an egg:	__Yes __No
Couple using a sperm donor:	__Yes __No
An older couple:	__Yes __No
A couple with children:	__Yes __No
An African American couple:	__Yes __No
A Jewish couple:	__Yes __No
A Caucasian couple:	__Yes __No
A Hispanic couple:	__Yes __No
An Indian couple:	__Yes __No
An international couple (Living outside of the U.S.)	__Yes __No
A non-English speaking couple with a translator:	__Yes __No

23. Please list the couples you would not be interested in working with, if not listed above.

_____

24. Have you applied or are you currently applying to be a gestational carrier at any other medical facility, law firm and/or agency? ___Yes___No

If yes, please list:_____

25. Have you ever applied to be a gestational carrier at any other medical facility, law firm, and/or agency and been told you do not meet the facility's criteria to be a gestational carrier: ___Yes___No If yes, please explain: _____
_____

HEALTH INFORMATION

1. Do you have health insurance? ___Yes ___No

   If so, does it have maternity coverage? ___Yes ___No
   Health insurance company:

   Name: _____
   Address: _____
   Phone: _____

   Is your health insurance provided through a state agency or program? ___Yes ___No

2. Allergies: _____

3. Do you have any medical problems? ___Yes ___No If yes, please explain:

   _____

4. Number of pregnancies: _____

5. Dates of each pregnancy: _____

6. Number of miscarriages: _____

7. Dates of each miscarriage: _____

8. Number of abortions: _____

9. Dates of each abortion: _____

10. Number of stillbirths: _____

11. Dates of each stillbirth: _____

12. Are your menstrual periods regular? ___Yes ___No

13. How long is your monthly cycle? _____

14. Do you have bleeding between periods? _____

15. How would you describe any cramping you have during your period?
_____

16. Is there anything unusual about your monthly cycle? ___Yes ___No If yes, explain:
_____

17. How many days does your period last? _____ days

18. How was each of your children conceived? ___Naturally ___With medical intervention

19. Are you presently using birth control? ___Yes ___No If yes, please state current method:

20. How long have you used this method of birth control? _____

21. Do you smoke cigarettes? ___Yes ___No If yes, how often? _____

22. Does any member of your family smoke cigarettes? ___Yes___No If so, who and how often?
_____

23. Have you ever smoked cigarettes? ___Yes ___No If so, when? _____

24. Do you drink alcohol? ___Yes ___No If yes, how often? _____

25. Have you ever used illegal drugs or un-prescribed drugs? ___Yes ___No
If yes, what drugs and how often? _____

26. Has you husband/partner used illegal drugs or un-prescribed drugs? ___Yes ___No
If yes, what drugs and how often? _____

27. Give a history of all previous pregnancies, including physical and emotional problems during and after each pregnancy (give delivery date, sex and weight of baby and list any complications). Please indicate if the birth(s) were vaginal or cesarean section:
_____
_____
_____

28. Do any of your children have serious health problems? ___Yes ___No If yes, please explain:
_____

29. Are you currently breastfeeding? ___Yes ___No If so, when do you plan to stop? _____

30. Do you have a history of any eating disorders? ___Yes ___No If yes, please describe:
_____

31. Would you be willing to undergo amniocentesis or other diagnostic testing to determine the presence of birth defects? ___Yes ___No

32. Have you ever had surgery? ___Yes ___No If yes, reasons and results?
_____

33. List all serious illnesses and hospitalizations:
_____

34. List all medications you are presently taking and the reasons for each:
_____

35. Have you gotten a tattoo or any body piercing within the last year and a half? ___Yes ___No

36. Have you ever been seen by a professional for mental health issues? ___Yes ___No
If yes, please explain and list time periods: _____
_____

37. Have you ever experienced any post-partum depression? ___Yes ___No
If yes, please give the details and time periods: _____
_____

38. Have you ever been prescribed or taken any medications for depression or mental health?
___Yes ___No If yes, please list the medications, reason for it and time periods:
_____

39. Have you ever had any problems with drug or alcohol abuse? ___Yes ___No
If yes, please give the details: _____

40. If any of your children are deceased, what was the age and cause of death:
_____

41. Are you exposed to excess heat in the way of saunas, hot tubs, and steam rooms? ___Yes ___No
If yes, please explain: _____

42. Do you have any allergies? ___Yes ___No
If yes, please explain in detail: _____

43. Blood type: _____ RH Factor: ___Positive ___Negative

44. Have you ever been advised to limit your use of alcohol or any other drug? ___Yes ___No
If yes, please explain: _____

45. Have you ever been advised to have any medical test and/or surgical procedure and failed to take such advice? ___Yes ___No If yes, please explain: _____
_____

46. Number of months between stopping birth control and conception? _____

47. Have you ever been seen by a doctor for infertility? ___Yes ___No

48. Did your mother take DES while pregnant? ___Yes ___No

49. Have you ever been told that you were infertile? ___Yes ___No

50. Have you delivered any children with birth defects? ___Yes ___No

51. Have your parents had any serious mental or physical illness? ___Yes ___No

52. If either of your parents are deceased what was their age and cause of death?
_____

SEXUAL HISTORY

1. List any contraceptives you have used in the past and any reaction you had to the use of the contraceptive? _____
2. Which method do you currently use? _____
3. Are you with a sexual partner now? ___Yes ___No
4. Which method does your partner currently use? _____
5. Please indicate with whom you have had sexual contact: ___Men ___Women ___Both
6. Do you currently have more than one sexual partner? ___Yes ___No
7. How many sexual partners have you had in the past three years? _____

8. Have you had sexual contact with a person you do not know well? ___Yes ___No

9. In the past 10 years, have you had sexual contact with anyone in a high risk group for A.I.D.S.? These include sexually active persons with multiple partners. ___Yes ___No

10. To your knowledge, have any of your sexual partners been sexually active with anyone in a high risk group for A.I.D.S.? ___Yes ___No

11. Are you at risk for A.I.D.S.? ___Yes ___No

12. Have you ever used IV drugs? ___Yes ___No

13. Have you ever received a blood transfusion? ___Yes ___No

14. Have you ever had a sexually transmitted disease? ___Yes ___No If yes, please explain:
    _____

15. Have you or any member of your family had a personal experience with any of the following: Serious accident or crime, rape, assault, incest, or sexual or physical abuse or victim of any crime?
    ___Yes ___No If yes, please explain:
    _____

EMPLOYMENT INFORMATION

1. Please list your current and previous place of employment, including positions held, dates of employment, and locations of each employer:
    _____
    _____

2. Please list your husband's/partner's current employment, including his position held, and location of employer:
    _____

3. Your current income: _____

4. Are you receiving food stamps or any other public assistance as part of your income?
    ___Yes ___No If yes, please specify:_____

5. Husband's/partner's current income: _____
6. How many persons do you support including yourself? _____

EDUCATIONAL HISTORY

1. Please choose highest level attained (only choose one):

   a. ___ Completed through grade _____
   b. ___ Graduated high school
   c. ___ Attended college through (circle one) freshman, sophomore, junior, senior year
   d. ___ Graduated college- List degrees: _____
   e. ___ Post Graduate: _____
   f. ___ Other (trade school, etc.) _____

GENERAL QUESTIONS

1. Please list any problems you or your spouse/partner have experienced with the law, including, but not limited to, any arrests, convictions, or sentences:
   _____
   _____

2. Have you or your spouse ever served any time in jail? ___Yes ___No
   If so, how much time did you serve and why?
   _____

3. Briefly explain your understanding of what being a gestational carrier will entail?
   _____
   _____
   _____

4. Generally, please describe yourself, i.e., your personality, hobbies, and interests:
   _____
   _____
   _____

5. What qualities would you consider most important that the intended parents have?
   _____
   _____

6. Would you permit the intended parents in the delivery room? ___Yes ___No

7. Would you permit the intended parents to attend doctor's appointments if they wanted to attend? ___Yes ___No

8. Would you permit the intended parents to notify the hospital that you were not the biological parent? ___Yes ___No

9. Would you allow the intended parents' names to be placed on the birth certificate? ___Yes ___No

10. Would you be willing to pump, freeze, and ship breast milk if your intended parents requested it for their child? ___Yes ___No

11. Please rate how important the following factors were to you in making the decision to apply to be a gestational carrier (1= most important)

    a. _____ I like being pregnant, but don't want any more children of my own.
    b. _____ I need the money.
    c. _____ Giving an infertile couple a child would bring me happiness.
    d. Other please specify: _____

12. Have you ever been an egg donor? ___Yes ___No If yes, when?_____

13. Have you ever been a gestational carrier or surrogate mother before? ___Yes ___No
    If yes, please describe your experience on a separate sheet of paper.

14. Have you ever placed a child for adoption? ___Yes ___No
    If yes, please describe your experience on a separate sheet of paper.

15. Are you adopted? ___Yes ___No

16. Are any of your children adopted? ___Yes ___No

17. Have you ever cared for a foster child? ___Yes ___No If yes, please explain briefly:
    _____
    _____

18. How do you feel about carrying twins?
    _____

19. Although triplets are not too common, please tell us if you would agree to carry triplets as long as your health and the babies' health were not in jeopardy? ___Yes ___No

20. If the embryo transfer resulted in triplets, and it is the treating physician's medical opinion to reduce from three to two due to your health and/or the health of the other fetuses, how would you feel? _____
_____

21. If your health and/or the health of one of the fetuses is in danger, and it is the treating physician's medical opinion to reduce two to one, how would you feel?
_____
_____

22. How much contact or information about the child after birth would you like?
Please specify. _____

23. Do you feel confident that you will not hesitate to give the couple the child(ren) you will carry for them? ___Yes ___No

24. What kind of support do you expect for being a gestational carrier from your significant other, siblings, parents, friends, and co-workers? Please give a detailed answer.
_____
_____

25. How does your husband/partner feel about your participation in this program? Please describe in detail.
_____
_____

26. Do you have any guns in your home? ___Yes ___No If yes, please describe why and where they are kept.
_____

27. Do you lease a car, own a car, or have access to public transportation? (Please specify).
_____

28. Is your vehicle insured? ___Yes ___No

29. Do you have a valid driver's license? ___Yes ___No