



The
Surrogacy
Center
LLC®
HELPING FAMILIES GROW

450 S. Yellowstone Dr.
Madison, WI 53719
Tel: 608-821-8230
TF: 866-684-BABY (2229)
Fax: 608-821-8201
surrogacycenter.com

**PERSONAL INFORMATION
POTENTIAL GESTATIONAL CARRIER**

Full Legal Name _____ Date of Birth _____
Street Address _____ County _____
City, State, Zip _____
Social Security No. _____ Driver's License No. _____
Home Phone _____ Cell Phone _____
Work Phone _____ Fax _____
Email Address _____

Name as it appears on birth certificate _____
Place of birth (City and State) _____

If applicable:

Employer's Name, Address and telephone number _____

Name and location of school most recently attended: _____

Please provide the following information with respect to your physician:

Name _____
Address _____
Telephone Number _____ Fax _____
Specialty, if any _____

If applicable:

Husband/Partner's Full Legal Name _____
Date of Birth _____
Social Security No. _____ Driver's License No. _____
Employer's Name, Address and telephone number _____

Name and location of school most recently attended: _____



The
Surrogacy
Center^{LLC®}
HELPING FAMILIES GROW

450 S. Yellowstone Dr.
Madison, WI 53719
Tel: 608-821-8230
TF: 866-684-BABY (2229)
Fax: 608-821-8201
surrogacycenter.com

**APPLICATION FOR SERVICES
POTENTIAL SURROGATE/GESTATIONAL CARRIER**

First Name _____ Age _____

Are you employed?

Yes _____ No _____

If you have answered yes:

Occupation _____ Length of Employment _____

Highest level of education completed _____ Year Graduated _____

Are you a U.S. citizen?

Yes _____ No _____

If not, please explain:

Have you ever been arrested?

Yes _____ No _____

If you have answered yes, were you convicted?

Yes _____ No _____

If you have answered yes to either question, please explain:

Are you currently receiving any form of public assistance?

Yes _____ No _____

If you have answered yes, please share what type of assistance you are receiving:

Please indicate your status:

Single _____ Married _____

If in a relationship, Husband's/Partner's first Name _____

Age _____

Is he/she employed?

Yes _____ No _____

If you have answered yes:

Occupation _____ Length of Employment _____

Highest level of education completed _____ Year Graduated _____

Has your husband/partner ever been arrested?

Yes _____ No _____

If you have answered yes, was he/she convicted?

Yes _____ No _____

If you have answered yes to either question, please explain:

If you are married, how many years? _____

Have you experienced significant marital problems?

Yes _____ No _____

If you have answered yes, please describe your problems, when they occurred, and how they were resolved:

If not married, are you living with someone in a committed relationship?

Yes _____ No _____

If you have answered yes, for how long have you been living together? _____

If you were previously married, what were the dates during which you were married?

For what reason did your marriage terminate?

Divorce _____ Husband's/Partner's Death _____

How would you describe yourself?

What do you feel are your best qualities?

Where, if at all, do you feel you would like to improve?

Do you consider yourself to have a stable lifestyle?

Yes _____ No _____

If you have answered no, please explain:

What are your plans for the future?

To how many children have you given birth? _____

Were all of your children born healthy?

Yes _____ No _____

If you have answered no, please explain:

Were any of your children born at an extremely high or low weight?

Yes _____ No _____

If you have answered yes, please explain:

Do you have children living in your home? _____

If so, please provide the following information:

Name _____

DOB _____ Sex _____ Birth weight _____

Name _____
DOB _____ Sex _____ Birth weight _____
Name _____
DOB _____ Sex _____ Birth weight _____
Name _____
DOB _____ Sex _____ Birth weight _____

Have you placed any children for adoption?

Yes _____ No _____

If you have answered yes, please give the details of your circumstances at the time of each placement:

If you have birth children who have not been placed for adoption but who do not live with you, please state the reasons for each child's not living with you:

Do you feel that your family is complete?

Yes _____ No _____

Have you ever had any abortions, miscarriages or stillbirths?

Yes _____ No _____

If you have answered yes, please describe the circumstances of each:

Were any of your children born premature?

Yes _____ No _____

If the answer is yes, please describe the circumstances of each birth:

Were any of your children delivered by C-section?

Yes _____ No _____

If you have answered yes, please describe the reason for each C-section:

Is it your understanding that future births will also be by C-section?

Yes _____ No _____

Have you had other complications with any pregnancy or birth?

Yes _____ No _____

If you have answered yes, please describe each complication:

Have you discussed the potential risks of another pregnancy with your OB/GYN given your medical history?

Yes _____ No _____

If you have answered yes, does your physician feel that you are medically safe to carry another pregnancy?

Yes _____ No _____

Are you currently using any form of birth control?

Yes _____ No _____

If you have answered yes, what form of birth control do you use?

Is your menstrual cycle regular?

Yes _____ No _____

About how long is your menstrual cycle? _____

What was the date of your last gynecological exam? _____

How would you rate your physical health?

Excellent _____ Good _____ Fair _____ Poor _____

If not excellent, please explain:

Please state your: Height _____ Weight _____

Do you currently smoke cigarettes?

Yes _____ No _____

If you have answered yes, how long have you been smoking and how many cigarettes do you smoke in one day? _____

Does anyone else who lives in your household smoke cigarettes?

Yes _____ No _____

If you have answered yes, please state who is the smoker, how many cigarettes they smoke in one day and where they smoke:

Do you drink alcohol?

Yes _____ No _____

If you have answered yes, how many drinks do you have:

Per day _____ Per week _____ Per month _____

Have you ever used illegal drugs?

Yes _____ No _____

If you have answered yes, please provide the details:

Would you say you wear a seatbelt:

Always _____ Often _____ Occasionally _____ Never _____

Have you or your spouse/partner:

___ received a traffic ticket in the past five years?

___ ever received a ticket for an ordinance violation?

___ ever been convicted of a crime, including traffic matters?

___ ever been cited for or convicted of any offense involving alcohol or drugs?

If yes to any of the above, please explain:

Have you or your spouse/partner ever:

___ had your wages garnished?

___ filed a petition for bankruptcy?

___ had an involuntary petition for bankruptcy filed against you?

___ had a foreclosure action filed against you?
___ had a collection action of any kind filed against you?
___ had an eviction action of any kind filed against you?
___ been found to be insolvent or indigent?

If yes to any of the above, please explain:

Has any life insurer or health insurer ever refused to issue you an insurance policy?

Yes _____ No _____

If you have answered yes, please provide the details:

Do you have automobile insurance?

Yes _____ No _____

Please provide the page from your policy that states the terms of your coverage.

Have you ever been terminated from a job?

Yes _____ No _____

If you have answered yes, please provide the details:

Do you currently take any prescription medications?

Yes _____ No _____

If you have answered yes, please list the name, the dosage, and the purpose of each medication: _____

Have you ever been diagnosed with a sexually transmitted disease?

Yes _____ No _____

If you have answered yes, please provide the details:

Have you gotten any tattoos or body piercing within the last 6 months?

Yes _____ No _____

If you answered yes, please give the date: _____

Do you have any medical conditions of which we should be aware?

Yes _____ No _____

If you answered yes, please describe:

Have you ever been diagnosed with depression or any other psychological problem?

Yes _____ No _____

If you have answered yes, did you receive treatment?

Yes _____ No _____

Please provide the details of your diagnosis and/or treatment:

Have you ever been diagnosed with a learning disability?

Yes _____ No _____

If you have answered yes, please describe the diagnosis:

Are you willing to participate in a psychological evaluation?

Yes _____ No _____

If you have answered yes, will you sign a Release to allow the information to be shared with The Surrogacy Center, the Intended Parents you select, and the Clinic?

Yes _____ No _____

If you are married, will your husband/partner participate in a psychological evaluation?

Yes _____ No _____

If you have answered yes, will he/she sign a Release to allow the information to be shared with The Surrogacy Center, the Intended Parents you select, and the Clinic?

Yes _____ No _____

Will you sign Releases for The Surrogacy Center, the Intended Parents you select, and the Clinic to receive medical information from your medical care provider?

Yes _____ No _____

Do you have health insurance?

Yes _____ No _____

If you have answered yes, please provide the following information:

Name of the insurance company _____

If you have answered yes, please provide a copy of your policy or summary plan description with this Application.

To your knowledge, does your health insurance policy exclude medical care for pregnancy and/or delivery to a Gestational Carrier?

Yes _____ No _____

Have you previously served as a Gestational Carrier?

Yes _____ No _____

If you have answered yes, please describe your experience(s):

Are you willing to travel for any surrogacy-related procedures?

Yes _____ No _____

If you have children living with you, can you make adequate childcare arrangements when necessary?

Yes _____ No _____

How do you feel about taking daily medications?

How do you feel about possibly receiving daily injections for an extended period of time?

Are you willing to give up cigarettes, alcohol, drugs/medications (other than those approved by your physician) caffeine, and dangerous activities prior to and during the surrogacy/gestational carrier arrangement?

Yes _____ No _____

If you have answered no, please explain:

Are you willing to undergo amniocentesis or chorionic villi sampling if the Intended Parents request it, and your physician approves?

Yes _____ No _____

If your physician recommended bed rest, would this be a problem for you?

Yes _____ No _____

Are you willing to carry multiple fetuses?

Yes _____ No _____

If you have answered yes, up to how many fetuses are you willing to carry? _____

How many embryo transfers are you willing to undergo in order to achieve a successful pregnancy and birth? _____

Under what circumstances, if any, would you agree to abortion or selective reduction?

Please indicate for whom you would be willing to carry a child (mark all that apply):

_____ a heterosexual couple.

_____ a single male.

_____ a single female.

_____ a gay or lesbian couple.

_____ an individual or couple whose ethnic background is different from your own.

_____ an individual or couple whose religious background is different from your own.

_____ an individual or couple living in a different state.

_____ an individual or couple living in a foreign country.

Please list the characteristics you are seeking in Intended Parents (i.e., family background, occupations, religion, education, personality, hobbies, etc.):

Please describe the kind of relationship you hope to establish with the Intended Parents (before, during, and after, the pregnancy):

How do you feel about the Intended Parents' being with you for appointments with your physician?

How do you feel about the Intended Parents' being with you in the delivery room?

Would you like to request any contact with or information about the child after the child's birth?

Yes _____ No _____

If you have answered yes, please describe what contact/information you seek:

Would you consider carrying a second child within the next 2-5 years for the same Intended Parents?

Yes _____ No _____

Do you have any concerns about becoming a Surrogate/Gestational Carrier?

Yes _____ No _____

If you have answered yes, please list your concerns:

Do you have any concerns about your being able to relinquish a child born to you through a surrogate/gestational carrier arrangement?

Yes _____ No _____

If you have answered yes, please give the details of your concern:

Do your husband, partner, family members, and/or friends have any concerns about your becoming a Surrogate/Gestational Carrier?

Yes _____ No _____

Is your husband/partner aware of his responsibilities in the medical process and how willing is he/she to cooperate?

During a surrogacy/gestational carrier process, from whom can you expect to receive emotional support?

What assurances can you give the Intended Parents that you will not change your mind about working with them after being matched?

What is your timeline for serving as a Surrogate/Gestational Carrier?

information will not be released until I give specific authorization for such release. I agree to sign Releases for the Center to communicate with any mental health professional conducting or having conducted a psychological evaluation relating to the assisted reproduction procedures in which I seek to engage, with any of my medical care providers, and with the clinic selected to conduct assisted reproduction procedures.

DISCLAIMER, INDEMNIFICATION AND HOLD HARMLESS

I understand that the Center may, from time to time, refer me and/or Intended Parents to various outside professionals. These may include, without limitation: psychologists and other mental health professionals, accountants, medical doctors and other health care professionals, clinics, and financial institutions. I understand that neither I nor Intended Parents are required to use such professionals and that the Center does not control the activities of such professionals. I agree to release the Center and hold it harmless with regard to any and all claims which relate to the activities of any such professionals or as a result of any such referrals of me or Intended Parents.

TAXES

I understand that I am responsible for any tax consequences I or my spouse may experience as a result of any surrogacy/gestational carrier arrangement.

The statements and commitments made in this Application are, to the best of my knowledge and belief, correct and complete. I agree to provide additional information supplementing and updating the above answers, if it comes to my attention, subsequent to the submission of this Application. I understand that if I knowingly provide false information on this Application, it will be grounds for the Center to refuse to accept me into the program or to refuse to continue to work with me.

OTHER

I understand that this process may take some time. I further understand that The Surrogacy Center will expend resources in reliance on my participation in this program. I agree to remain available as a potential gestational carrier/surrogate in The Surrogacy Center's program for 12 months from the date of this application. I also agree that all written materials including pleadings, briefs, and other documents created by The Surrogacy Center are property of The Surrogacy Center and as such are not to be disclosed or distributed.

Signature

Date

If you have any questions about any information requested in this Application, feel free to call us at 608-821-8230 or toll-free at 866-684-BABY (2229).

Please return the completed Personal Information and Application to:

The Surrogacy Center LLC
450 S. Yellowstone Drive
Madison, WI 53719

Or email these forms to us at:

info@surrogacycenter.com