



The
Surrogacy
Center
LLC®
HELPING FAMILIES GROW

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

APPLICATION FOR SERVICES – INTENDED PARENTS

APPLICANT 1:

Full Legal Name

Previous Names Used

Current Address

Addresses Used in Past 7 Years

Home Telephone Cell Number

Work Telephone Fax

Email Address

Social Security # Date of Birth

Occupation

Employer's Name

Employer's Address

Employer's Telephone Number

Length of Employment

APPLICANT 2:

Full Legal Name

Previous Names Used

Current Address

Addresses Used in Past 7 Years

Home Telephone Cell Number

Work Telephone Fax

Email Address

Social Security # Date of Birth

Occupation

Employer's Name

Employer's Address

Employer's Telephone Number

Length of Employment

ALL APPLICANTS:

Please indicate your status:

Single Married Life Partnership Registered Domestic Partnership

Date of Marriage or commencement of Domestic or Life Partnership: _____

Do you have children? Yes No

If so, please provide their names, ages and if they live with you:

Has either applicant:

ever been arrested and/or convicted of a crime? Yes No

ever been cited for or convicted of any offense involving alcohol or drugs? Yes No

If yes to any of the above, please explain:

Has either applicant:

had your wages garnished? Yes No

filed a petition for bankruptcy? Yes No

had an involuntary petition for bankruptcy filed against you? Yes No

had a foreclosure action filed against you? Yes No

had a collection action of any kind filed against you? Yes No

had an eviction action of any kind filed against you? Yes No

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

Does either applicant have a health condition which impairs normal daily activities, is likely to significantly reduce life span, or may impair the ability to care for a child?

Yes No

If yes, please attach a description of the condition(s) for each applicant, provide the name, address and telephone number of the treating health care provider(s) and provide a signed authorization (you can obtain a form from your doctor's office) to allow The Surrogacy Center to obtain information about your medical condition(s).

Has either applicant participated in a psychological evaluation with respect to an assisted reproduction procedure, such as surrogacy or egg donation? Yes No

If no, are you willing to participate in such an evaluation? Yes No

If you have answered no, please explain:

If you have already participated in a psychological evaluation, please provide the following information:

Name of Evaluator

Name of Clinic

Address

Telephone Number

Fax

Email Address

Please provide a copy of the evaluation or a Release to allow The Surrogacy Center and the evaluator to communicate with each other and for The Surrogacy Center to receive a copy of the evaluation.

SURROGACY PROCESS

What has led you to the decision to pursue surrogacy?

You plan to use (mark all that apply): Your own egg and sperm Egg Donor
 Sperm Donor

How many embryo transfer attempts are you willing to undergo to achieve a successful pregnancy? _____

Are you willing to have the Gestational Carrier carry multiple fetuses? Yes No
If you have answered yes, how many? _____

Would you be interested in a Gestational Carrier who would possibly carry another child for you in the future? Yes No

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

Do you have any time constraints for being introduced to a potential Gestational Carrier?

Please list the characteristics you are seeking in a Gestational Carrier:

Do you have any requirements or limitations regarding the woman who will carry your baby? If so, please explain:

- Marital Status: _____
- Sexual Orientation: _____
- Ethnicity: _____
- Religion: _____
- Other: _____

Please list the characteristics you are seeking in a Gestational Carrier:

Please describe the kind of relationship you expect or hope to establish with the Gestational Carrier (before, during and after the pregnancy):

Are you working with an attorney? Yes No

If yes, please provide the attorney's information:

Name

Address

Telephone Number

Fax

Email Address

Has your attorney completed any documents for you relating to the assisted reproduction procedures you seek? Yes No

If yes, please indicate which documents have been completed and provide copies with this Application:

Are you currently working with a fertility clinic? Yes No

If yes, please provide the following information:

Name of Clinic

Will you agree to keep The Surrogacy Center informed regarding any changes in any of the information you have provided on this application? Yes No

Completing a successful surrogacy arrangement requires a lot of forethought and planning, and can be one of the most rewarding experiences of your life. Our goal is to help guide and support you throughout your surrogacy journey. We welcome the opportunity to help you grow your family.

UNDERSTANDING, AGREEMENT AND CONSENT

In completing this Application to The Surrogacy Center, I understand that The Surrogacy Center has not committed to accept me into its program. I understand that the \$350.00 application fee is non-refundable, regardless of whether I am accepted into the program.

I will sign all Releases requested by The Surrogacy Center in order for a determination to be made on my Application, including Releases for The Surrogacy Center to communicate with any mental health professional conducting or having conducted a psychological evaluation, with any of my health care providers and with the clinic I choose to conduct assisted reproduction procedures.

I hereby agree that The Surrogacy Center may provide non-identifying information about me to the potential Gestational Carrier prior to any meeting with a Gestational Carrier. I understand that identifying information will be released when I give authorization for such release.

I consent to The Surrogacy Center conducting any and all background checks using my personal information, which it deems appropriate, including, without limitation, financial, criminal, civil, social media and Internet searches.

The statements and commitments made in this Application are, to the best of the undersigned's knowledge and belief, correct and complete. I agree to provide additional information supplementing and updating the above responses which comes to my attention subsequent to the submission of this Application. The Surrogacy Center is relying on the information I have provided. I understand that I have no vested right to participate in the program. The Surrogacy Center will decide whether to accept my Application based on any factors it deems relevant, some of which may have nothing to do specifically with me. If I provide false information on this Application, The Surrogacy Center may refuse to accept me into the program or terminate my participation in the program. I agree that all documents and written materials generated in this process, including pleadings, agreements and other documents created by The Surrogacy Center or its attorneys are property of The Surrogacy Center and may not be disclosed or distributed.

Signature

Date

Signature

Date

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

Please return this completed document with the
\$350.00 non-refundable application fee to:
The Surrogacy Center LLC
450 S. Yellowstone Drive
Madison, WI 53719