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
INTENDED PARENTS

APPLICANT 1:

Name ____
Street Address ____
City, State, Zip ____
Home Phone ________________________ Cell Phone __________________________
Work Phone ________________________ Fax _______________________________
Email Address ____
Social Security No. ___________________ Date of Birth _________________________
Occupation _________________________ Length of Employment _________________
Employer's Name and Address ____
____
____

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:
____
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Do you have a health condition which impairs your normal daily activity, is likely significantly to reduce your life span, or will impair your ability to care for a child?
Yes _____ No _____
If you have answered yes, please sign a Release to allow the appropriate health care provider and The Surrogacy Center to discuss your medical condition and to allow the health care provider to send copies of any relevant written materials to The Surrogacy Center. The Release should be mailed or faxed to the provider or The Surrogacy Center as soon as possible.

Have you participated in a psychological evaluation with respect to becoming involved in an assisted reproduction procedure?
Yes _____ No _____

If you have answered no, are you willing to participate in such an evaluation?
Yes _____ No _____
If you have answered no, please explain:
____
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If you have already participated in a psychological evaluation, do you have a copy of that evaluation?
Yes _____ No _____
If you have answered yes, please provide a copy to The Surrogacy Center with this Application.
If you have answered no, please provide the following information:
Name of Evaluator ____
Name of Clinic ____
Address ____
Telephone Number _________________________ Fax ______________________________
Email Address ____
Please sign 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. The Release should be mailed or faxed to the evaluator and The Surrogacy Center as soon as possible.

APPLICANT 2:

Name ____
Street Address ____
City, State, Zip ____
Home Phone __________________________ Cell Phone __________________________
Work Phone __________________________ Fax ________________________________
Email Address ____
Social Security No. ____________________ Date of Birth ________________________
Occupation ___________________________ Length of Employment _________________
Employer's Name and Address ____
____
____

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:
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Address ____
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Email Address ____
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ALL APPLICANTS:

Please indicate your status:
Single __________ Married __________ Life Partnership __________
Date of Marriage or Commencement of Life Partnership ________________________________
Please attach a copy of your Certificate of Marriage or Domestic Partnership.

Do you have children living in your home?
If so, please provide the following information:
Name ____
DOB _________________ Sex ________________
Name ____
DOB _________________ Sex ________________
Name ____
DOB _________________ Sex ________________
Name ____
DOB _________________ Sex ________________

Please indicate whether you are seeking to achieve a pregnancy through (mark all that apply):
Surrogate ____ Gestational Carrier ____ Egg Donor ____ Sperm Donor ____

What has led you to this decision?
____
____
____
____
____
____
____

How many embryo transfers are you willing to undergo to achieve a successful pregnancy?
____

Do you wish for the Surrogate/Gestational Carrier to carry multiple fetuses?
Yes _____ No _____
If you have answered yes, how many? _____

Would you like the Surrogate/Gestational Carrier to possibly carry another child for you in the future?
Yes _____ No _____

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

What is your timeframe for being introduced to a potential Surrogate/Gestational Carrier?

____
____
____

Please indicate whom you would want to carry your child: (mark all that apply):
_____ a heterosexual female.
_____ a single female.
_____ a lesbian.
_____ a woman whose ethnic background is different from your own.
_____ a woman whose religious background is different from your own.
_____ a woman living in a different state.
_____ a woman living in a foreign country.

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

____
____
____
____
____
____

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

____
____
____
____
____
____

Are you working with an attorney?
Yes _____ No _____
If you have answered yes, please provide the attorney's:
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 you have answered yes, please indicate which documents have been completed and provide copies with this Application:

____
____
____
____
____

Are you currently working with a clinic?
Yes _____ No _____
If you have answered yes, please indicate the following:
Name of Clinic ____
Address ____
Telephone Number ____________________ Fax ____________________
Name of primary physician with whom you are working ____________________
Name of primary nurse with whom you are working ______________________

What, if any, arrangements have been made with the clinic for the type of assisted reproduction to be used?

How did you hear about The Surrogacy Center?

Please write a personal note which describes you and your family. You might want to include details about your daily life and your family background. (Please feel free to include a photo if you wish.)

Completing a successful surrogacy/gestational carrier arrangement is a complex and delicate matter, but with much thought and good communication, it can be one of the most rewarding experiences of your life. We very much look forward to working with you toward this goal.

UNDERSTANDING

In completing this Application to The Surrogacy Center (“Center”), I/we understand that the Center is not making a commitment that my/our Application will be accepted. I/we understand that the $350.00 fee is non-refundable regardless of whether or not I/we are accepted into the Program. I/we will sign all Releases requested by the Center in order for a determination to be made on our Application. I/we hereby consent to the Center’s providing non-identifying information about me/us to potential Surrogates/Gestational Carriers prior to any meeting with a Surrogate/Gestational Carrier. I/we understand that identifying information will not be released until I/we give specific authorization for such release. I/we 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/we seek to engage, with any of my/our medical care providers, and with the clinic I/we choose to conduct assisted reproduction procedures. The statements and commitments made in this Application are, to the best of my/our knowledge and belief, correct and complete. I/we agree to provide additional information supplementing and updating the above answers, if it comes to my/our attention, subsequent to the submission of this Application. I/we understand that if I/we knowingly provide false information on this Application, it will be grounds for the Center to refuse to accept me/us into the program or to refuse to continue to work with me/us. I/we also agree that all documents written materials, including pleadings, briefs, and other documents created by The Surrogacy Center are property of The Surrogacy Center and as such are 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).

Please return this completed document with the
$350.00 non-refundable application and consultation fee to:

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