

# Fertility Alternatives, Inc.

32143 Zion Way, Winchester, CA 92596

Ph: 858- 391-8393

Fax: 858-630-5500

FertilityAlternatives@Gmail.com

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## Egg Donor Application Form:

**(PLEASE FILL OUT THOROUGHLY IN BLACK OR DARK BLUE PEN)**

First Name **Only**: \_\_\_\_\_ Age \_\_\_\_\_ Birth date: \_\_\_\_\_

Height: \_\_\_\_\_ Normal/Average weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Natural hair color: \_\_\_\_\_ Natural Hair type: Straight / Wavy / Curly / Very Curly

Thick hair \_\_\_\_\_ Average texture \_\_\_\_\_ Thin texture \_\_\_\_\_

Skin color: Fair \_\_\_\_\_ Medium \_\_\_\_\_ Olive Lt Brown Dk Brown \_\_\_\_\_ Ebony Freckled \_\_\_\_\_ Rosy \_\_\_\_\_

Body Frame: Small / Medium / Large Right Handed/ Left Handed / Ambidextrous

Ethnic Background (The countries where your families/ancestors are originally from.

Unless you are Native American, please do not answer, U.S.A): \_\_\_\_\_

\_\_\_\_\_

Race: \_\_\_\_\_ Religious background: \_\_\_\_\_

Blood Type: \_\_\_\_\_ *If you do not know your blood type, please contact your physician for that info, at your earliest convenience. This is really helpful, but not a requirement.*

Marital status: Single / Engaged / Married / Divorced / Separated / Widowed

How many children do you have? \_\_\_\_\_ Do you have any adopted children? \_\_\_\_\_

Do you carry any health insurance? \_\_\_\_\_ Name of health insurance company? \_\_\_\_\_

Effective date: \_\_\_\_\_ Deductible: \_\_\_\_\_

## EDUCATIONAL BACKGROUND

Were you in the gifted program in elementary school? \_\_\_\_\_

Did you graduate from high school? \_\_\_\_\_ What year did you graduate? \_\_\_\_\_

Were you taking any advanced courses? \_\_\_\_\_ If yes, which ones? \_\_\_\_\_

\_\_\_\_\_

Favorite subjects: \_\_\_\_\_

What was your approximate high school GPA? \_\_\_\_\_

What were your PSAT, SAT or ACT scores? \_\_\_\_\_

*(please write N/A if you did not take either of these tests.)*

Do you have documentation proving your SAT or ACT scores? \_\_\_\_\_  
(If you took these tests, a copy will be required, along with any other documentation  
required for "Exceptional Donor" Status)

Were you a member of Honor Societies, Academic Distinctions? \_\_\_\_\_ If yes, which  
ones? \_\_\_\_\_

Did you attend a college or university? \_\_\_\_\_ If so, when and where and your current educational  
progress?: \_\_\_\_\_

AA/AS earned: Major: \_\_\_\_\_ Minor: \_\_\_\_\_ Years attended/GPA: \_\_\_\_\_

BA/BS earned: Major: \_\_\_\_\_ Minor: \_\_\_\_\_ Years attended/GPA: \_\_\_\_\_

MA/MS earned: Major: \_\_\_\_\_ Minor: \_\_\_\_\_ Years attended/GPA: \_\_\_\_\_

Ph.D or other Doctorate: Major \_\_\_\_\_ Minor: \_\_\_\_\_ Years attended/GPA: \_\_\_\_\_

Other training/certificates: \_\_\_\_\_

What social clubs were you a member of in college? \_\_\_\_\_

Do you plan to pursue/are you pursuing now an advanced degree? \_\_\_\_\_ If yes, in  
what subject? \_\_\_\_\_

If you have taken any of these other tests, what were your scores? GMAT \_\_\_\_\_ GRE \_\_\_\_\_  
MAT \_\_\_\_\_ LSAT \_\_\_\_\_ MCAT \_\_\_\_\_

(If you took these tests, a copy will be required for "Exceptional Donor" Status)

Do you have any further educational plans / goals? \_\_\_\_\_ Please explain:

Have you ever taken an I.Q. test? \_\_\_\_\_ What were the results? \_\_\_\_\_

Are you able to get a copy of such results? \_\_\_\_\_

Are you open to taking an I.Q. test? \_\_\_\_\_

Other than English, what other languages do you or your family speak & write?

### GENERAL QUESTIONS

Have you ever been an Egg Donor before? \_\_\_\_\_ If so, Please describe what you  
know about the results from your other donation(s). (Please be as specific as possible, to  
include the number of eggs, and dates. Do not list the agency.):

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Where did you learn about egg donation? \_\_\_\_\_  
\_\_\_\_\_

Why would you like to be an egg donor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you expect to receive support from your immediate family? \_\_\_\_\_ If not, will this affect your willingness or ability to follow through with your decision to act as an egg donor?

If you are telling them, how does your extended family feel about your decision to be an egg donor? \_\_\_\_\_

Egg Donation requires a strong commitment and the ability to follow instructions exactly. How can you reassure the couple that you will not change your mind about following through with your decision to be their egg donor and that you do infact understand what will be required of you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Donors in most cases will be asked to travel one or two times for the cycle. Is your schedule flexible enough to allow travel? \_\_\_\_\_ If you have partial travel limitations, please explain in detail if possible any expected availability for travel.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Travel for the screening will take about a day or two. Travel for the Egg retrieval will be about a 7-10 days, if main clinic is not within a driving distance.)*

Do you own a car? \_\_\_\_\_ Do you have car insurance? \_\_\_\_\_ Do you have a valid driver's license \_\_\_\_\_? Do you have adequate and reliable transportation for necessary medical appointments? \_\_\_\_\_  
Describe your relationship with your husband / partner, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you feel about the possibility of the child wanting to meet you in the future or any request from the Intended Parents, that you be available to meet the child in the future?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you willing to keep your contact and family health history information up to date annually for a minimum of 18 years if there is a child born? Some Intended Parents will require this.  
If no, why not?

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Are you open to meeting the Intended Parents if they request it?  
(The match can remain anonymous if you choose.) \_\_\_\_\_ If not, why?

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Assuming this is an OPEN donation, how much contact do you want the Intended Parents after their child / children are born, if any? If you prefer an anonymous donation write "N/A".

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*All matches will be anonymous or semi-anonymous, unless agreed upon by the Parties in advance.*

Are you adopted? \_\_\_\_\_ If yes, do you have complete information regarding the genetic history of your birth parents, in order to fill out the rest of this application? \_\_\_\_\_  
*You are required to have this information in order to be accepted into the program.*

**REPRODUCTIVE/HEALTH HISTORY**

| <b>Pregnancy History</b>                              | <b>Pregnancy #1</b> | <b>Pregnancy #2</b> | <b>Pregnancy #3</b> | <b>Pregnancy #4</b> | <b>Pregnancy #5</b> |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
| <b>Months to conceive.</b>                            |                     |                     |                     |                     |                     |
| <b>Date of Delivery</b>                               |                     |                     |                     |                     |                     |
| <b>Miscarriage?</b><br>(How many weeks of pregnancy?) |                     |                     |                     |                     |                     |
| <b>Abortion?</b> List date                            |                     |                     |                     |                     |                     |
| <b>Stillbirth?</b><br>How far along?                  |                     |                     |                     |                     |                     |
| <b>Premature birth?</b><br>How far along?             |                     |                     |                     |                     |                     |
| <b>Gender</b>   |                     |                     |                     |                     |                     |
| <b>Birth Weight</b>                                   |                     |                     |                     |                     |                     |
| <b>Meds used?</b>                                     |                     |                     |                     |                     |                     |
| <b>Problems w/ delivery?</b>                          |                     |                     |                     |                     |                     |
| <b>Multiple birth?</b>                                |                     |                     |                     |                     |                     |

Does your sexual partner/husband understand that he will also be required to undergo a blood screening to make sure he is free of STDs, HIV, and other communicable diseases?

\_\_\_\_\_

Have you ever had sexual intercourse? \_\_\_\_\_  
Do you have a regular menstrual cycle? \_\_\_\_\_ If yes, how many days between periods? (Day 1 being the first day of your period.) \_\_\_\_\_

Are you currently breastfeeding? \_\_\_\_\_ If so, when do you plan to stop?

**\*If you have been pregnant more than five times, please list additional pregnancies on the back of this sheet.**

Have twins or multiple births occurred in your family **Yes / No**

Have any previous donations resulted in an identical split of any of the embryos, that you know of? \_\_\_\_\_ If yes, How many? \_\_\_\_\_ (Write N/A, if this does not apply to you.)

Have you ever experienced any pregnancy complications such as, pre-term labor, gestational diabetes, Placenta Previa, emergency cesarean, home monitoring, etc...?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What form of birth control are you currently using? \_\_\_\_\_ How long? \_\_\_\_\_ If you are on BC pills, what is the name of the brand you are taking?

*(If you are taking Depo Provera or any other long term hormonal birth control method, (except for birth control pills) it must be discontinued for as long as you choose to be in the program.*

Date of last visit to OB/GYN \_\_\_\_\_

Date of last Pap smear? \_\_\_\_\_

Have you ever had an abnormal Pap smear? \_\_\_\_\_ If so, what was the reason and medication prescribed for it? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you tested positive for any type of sexually transmitted disease or virus that is incurable? (I.e. Herpes Simplex II, etc.) \_\_\_\_\_ If yes, what? \_\_\_\_\_

\_\_\_\_\_

Have you been diagnosed as a carrier of HPV (Human Papilloma Virus)? \_\_\_\_\_

If so, have you had a culposcopy or a cone biopsy performed? \_\_\_\_\_ If so, when? \_\_\_\_\_

Do you have regular pap smears as a result? \_\_\_\_\_

Do any of your children have any health or genetic problems? \_\_\_\_\_

If so, what are they? \_\_\_\_\_

\_\_\_\_\_

**GENERAL HEALTH**

Do you smoke? \_\_\_\_\_ Does anyone in your home, smoke? \_\_\_\_\_  
Smokers will not be accepted into the program, and any person in the home who smokes must do so outside. Is this acceptable to you? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have any pets? If so what type? \_\_\_\_\_

Have you had any severe weight change in the last five years for any reason other than pregnancy? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What type of medications are you currently taking? For what purpose? \_\_\_\_\_

\_\_\_\_\_

*Please be advised that if you are taking any medications other than Birth control pills, you may not be eligible for the program. You will not qualify for the program if you are taking any anti-anxiety or anti-depressant medications.*

Do you use recreational drugs? YES / NO

*Please be advised that you will not be accepted into the program if you use recreational drugs. All applicants who are matched will be required to undergo a full drug screen before and during the egg donor cycles.*

Are you allergic to any medications? If so, which ones? \_\_\_\_\_

\_\_\_\_\_

Have you been diagnosed with clinical depression or anxiety not related to pregnancy or a crisis? \_\_\_\_\_

*Please be advised that if you have been diagnosed with clinical depression or anxiety and/or taking long term medications to control either, you are not eligible for the program.*

Do you have any health problems? \_\_\_\_\_ If so, what are they?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_ If so, for what purpose and when?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any tattoos or body piercing in the last 12 months? Yes \_\_\_\_\_ No

*(If yes, you are required to wait a minimum of 12 months before you can do an egg donor cycle, due to the FDA regulations.)*

**FAMILY MEDICAL HISTORY**

Are you of Jewish Ancestry? \_\_\_\_\_ Have you been tested for Tay Sachs disease or other Jewish related diseases? \_\_\_\_\_ Results: \_\_\_\_\_

Is your mother, father, or both Jewish? \_\_\_\_\_

If you are Jewish, do you have any documentation to show that you are Jewish for special circumstances? (i.e. Family records, etc) \_\_\_\_\_ If yes, what \_\_\_\_\_

Are you of African Ancestry? \_\_\_\_\_ If so, Have you been tested for Sickle Cell disease? \_\_\_\_\_ Results: \_\_\_\_\_

Cystic fibrosis (if Caucasian) carrier non carrier \_\_\_\_\_ unknown \_\_\_\_\_

Thalassemia (if Italian, Greek, East Indian) carrier \_\_\_\_\_ non carrier \_\_\_\_\_ unknown \_\_\_\_\_

Have you and/or your partner ever tested for HIV? \_\_\_\_\_ If yes, give dates and results for both/either of you? \_\_\_\_\_

Have you or any of your immediate family (parents, grandparents, aunts/uncles, siblings and children) ever had any of the following?

(If yes, list dates, family member with disorder, age of member affected, treatments.)

(indicate if family member is of your maternal or paternal side.)

Allergies/Asthma \_\_\_\_\_

Emphysema \_\_\_\_\_

Hypo or Hyper- Thyroid \_\_\_\_\_

Chronic Bronchitis \_\_\_\_\_

Liver Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Kidney Problems \_\_\_\_\_

Psychological Disorders (give name of disorder) \_\_\_\_\_

Epilepsy/ Convulsions \_\_\_\_\_

Heart Disease \_\_\_\_\_

Eye disease/ Retinal Blastoma \_\_\_\_\_

Lung Disease \_\_\_\_\_

Mental Retardation (or Fragile X syndrome) \_\_\_\_\_

Ulcers \_\_\_\_\_

Cancer (type) \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Deafness (Birth or childhood) \_\_\_\_\_

Cataracts/ Glaucoma \_\_\_\_\_

Blindness or Crossed Eyes \_\_\_\_\_

Glasses/ Contacts \_\_\_\_\_

Color blindness \_\_\_\_\_

Heart Attack (Age) \_\_\_\_\_

Hepatitis (A, B, or C) \_\_\_\_\_

Alzheimer's Disease \_\_\_\_\_

Cleft Palate/ Lip \_\_\_\_\_

Multiple Sclerosis \_\_\_\_\_

Down's Syndrome \_\_\_\_\_

Heart Murmur \_\_\_\_\_

Birth Deformities (describe) \_\_\_\_\_

Tay Sachs (or carry a mutation) \_\_\_\_\_

Stroke (age?) \_\_\_\_\_  
 Hemophilia \_\_\_\_\_  
 Anemia \_\_\_\_\_  
 Sickle Cell Anemia \_\_\_\_\_  
 HIV or AIDS \_\_\_\_\_  
 Leukemia \_\_\_\_\_  
 Skin Disorders \_\_\_\_\_  
 Spina Bifida \_\_\_\_\_  
 Cerebral Palsy \_\_\_\_\_  
 Muscular Dystrophy \_\_\_\_\_  
 Extreme Nervousness/Anxiety \_\_\_\_\_  
 Hyperactivity (If it was temporary, at what age did it end?) \_\_\_\_\_  
 \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Dwarfism \_\_\_\_\_  
 Cystic \_\_\_\_\_  
 Fibrosis \_\_\_\_\_  
 Paralysis \_\_\_\_\_  
 Alcoholism (more than two family members) \_\_\_\_\_  
 Learning Disability \_\_\_\_\_  
 High Blood \_\_\_\_\_  
 Pressure \_\_\_\_\_  
 Incontinence \_\_\_\_\_  
 Migraines \_\_\_\_\_  
 Hysterectomy \_\_\_\_\_  
 Cesarean Section \_\_\_\_\_

| Family     | Hair | Eyes | Height | Weight | Age | Health |
|------------|------|------|--------|--------|-----|--------|
| Mother     |      |      |        |        |     |        |
| MGM        |      |      |        |        |     |        |
| MGF        |      |      |        |        |     |        |
| Mat. Aunt  |      |      |        |        |     |        |
| Mat. Aunt  |      |      |        |        |     |        |
| Mat. Uncle |      |      |        |        |     |        |
| Mat. Uncle |      |      |        |        |     |        |
| Father     |      |      |        |        |     |        |
| PGM        |      |      |        |        |     |        |
| PGF        |      |      |        |        |     |        |
| Pat. Aunt  |      |      |        |        |     |        |
| Pat. Aunt  |      |      |        |        |     |        |
| Pat. Uncle |      |      |        |        |     |        |
| Pat. Uncle |      |      |        |        |     |        |
| Sibling #1 |      |      |        |        |     |        |
| Sibling #2 |      |      |        |        |     |        |
| Sibling #3 |      |      |        |        |     |        |
| Child #1   |      |      |        |        |     |        |

|          |  |  |  |  |  |  |
|----------|--|--|--|--|--|--|
| Child #2 |  |  |  |  |  |  |
| Child #3 |  |  |  |  |  |  |
| Child #4 |  |  |  |  |  |  |

Are any of your family members listed above deceased? If so whom, their age and cause:

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How does your partner/husband feel about your interest in egg donation?

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What is your philosophy in life?

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What are your plans and goals for the future?

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Have you achieved any of these goals yet? \_\_\_\_\_? Which ones?

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Describe your biological parents and siblings. *(Include their personality and talents):*

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**Genetic Family intellectual/artistic interests:**

**Please state: Education / Occupation / Intellectual or Academic achievements /  
Artistic or other achievements**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

**Sisters**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Brothers**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Children**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Genetic family member's personality/talents:**

What personality traits and talents seem to run in your family?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your childhood personality. Were you obedient, shy, rebellious, outgoing, etc.

Give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_







**\*This page will remain completely confidential and will not be seen by prospective parents\***  
***The Following Questions must be filled out completely.***

Full legal name: \_\_\_\_\_ Maiden name: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Fax (where you can receive Egg donation documents): \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Current street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Last street address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social security number: \_\_\_\_\_ Driver's license number: \_\_\_\_\_  
Issuing state: \_\_\_\_\_  
Place of employment: \_\_\_\_\_  
How long? \_\_\_\_\_ Job description: \_\_\_\_\_  
Donor's Approximate gross daily wages: \_\_\_\_\_  
Gross annual family income: \_\_\_\_\_  
Husband's legal name: \_\_\_\_\_  
Husband's Place of employment and job description, and work number (he/she will only be contacted under extreme circumstances.): \_\_\_\_\_  
Person to contact in case of emergency or in the event you move or change your phone number: (not spouse/partner) Include their name, address, phone number and their relation to you. (Please make sure they know about your application as an egg donor): \_\_\_\_\_

\_\_\_\_\_

If you have completed egg donor cycles in the past, please list the names of the clinics where your egg retrievals were performed as well as the dates they were completed.

\_\_\_\_\_

What is your desired fee? \_\_\_\_\_ We will do everything we can to match you with your desired fee. However, please keep in mind that Fertility Alternatives, Inc., may not be able to match you if your fee is unreasonably high, based on the market conditions. If you have not been a donor in the past, you must qualify for "exceptional donor" status to be considered for compensation exceeding \$5000.

**I agree to inform " Fertility Alternatives, Inc." of any sexual involvement with a new partner at any time while I am an egg donor enrolled in this program. I further understand, that any new partner I have, must be tested for HIV and STD's prior to my being sexually active with them at my own cost, if the Intended parents have already provided a screening for a previous sexual partner. As well, I understand that as an egg donor, I will be required to undergo a psychological and medical screening to include but not limited to: Blood tests, drug testing, genetic testing, Pap smear, and other vaginal cultures.**

*Please include a photocopy of your drivers license and 3 or 4 clear, attractive photos of your face , with your application.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Husband/Partner's Signature \_\_\_\_\_ Date: \_\_\_\_\_

## **Fertility Alternatives, Inc. Egg Donor Program Agreement for Egg Donors**

I agree to exclusively use the services of Fertility Alternatives, Inc. to match me with a recipient couple or individual to donate my eggs/ovum.

I understand that it may take three (3) or more months to be matched with a Ovum recipient, and that it is standard to take up to six (6) months or more to find a match, based on what available recipients are looking for at any given time.

I understand that I must sign exclusively with Fertility Alternatives, Inc. as my agent and representative, and that by applying with other agencies or Egg Donor programs in addition to Fertility Alternatives, Inc., will not allow me to get matched any sooner, and may in fact be problematic, affecting my ability to get the best possible compensation, given market conditions.

I understand that that I may withdraw from Fertility Alternatives, Inc. egg donor program for any reason, however, I agree, in good faith, to give Fertility Alternatives, Inc. a reasonable amount of time to provide a match for me, prior to rescinding my contract and applying with other egg donor programs. A reasonable amount of time is defined as 18 months.

I understand as reasonable incentive for working exclusively with Fertility Alternatives, Inc., the agency will provide financial compensation to me for referring other potential egg donors (who eventually complete the process) to the agency.

I agree to make myself available within a reasonable time period, if a match is made. I understand that travel may be requested during an Egg Donor cycle. I understand that this is not a requirement, however may allow me to get matched sooner. I understand that travel is defined as approximately 1-3 days for the time of the screening, and 7-10 days for the time of the egg retrieval procedure. More or less, depending on my location and the location of the main clinic. I understand that all travel expenses will be paid by the Egg/Ovum recipients, through a Trust account provided by Fertility Alternatives, Inc. I understand that travel arrangements will be made by Fertility Alternatives, Inc.

I agree and understand that if travel is necessary, that an agent of Fertility Alternatives, Inc. may serve as my travel companion, for expressed purpose of providing transportation and support for the egg retrieval procedure, if other arrangements for a companion cannot be made.

Reasonable travel expenses for my alternate companion will be paid by the Egg/Ovum recipients and travel arrangements made by Fertility Alternatives, Inc. with my cooperation. Per-diem expense allowances will be paid to me in advance of my required travel dates.

My actual net lost wages or childcare will be covered for an amount not to exceed \$100 per travel day up to two (2) days after egg retrieval procedure. I am required to provide a pay stub in order to receive said lost wages or said childcare. I understand that any travel companion I elect to accompany me to my egg retrieval, will not be entitled to lost wage reimbursement.

If travel is not required, my actual net lost wages will be covered for an amount not to exceed \$100 per day for the day of the egg retrieval procedure, and up to two (2) days after. I am required to provide a pay stub to receive said lost wages.

I agree to allow Fertility Alternatives, Inc. to use my photos and likeness and non-identifying

information from my profile to show to prospective couples, individuals and for use on the internet database for matching purposes only. If I choose not to display my photos on the internet database, I may request as such in writing. I understand that if I choose not to display photos of myself on the database, that I may not be matched as an egg donor.

I understand that I may choose my own reasonable compensation as an Egg Donor. However, I agree to allow Fertility Alternatives, Inc. to advise me on what the industry standard of Egg Donor compensation is, based on my individual profile and experience, as unreasonably high compensation, can prevent my ability to become matched as an egg donor.

\$750 of said of compensation will be given to me upon start of the cycle by injectable medications. The balance of said compensation will be received within 7 days after the completion of the egg retrieval procedure and after any receipts are submitted, along with any other expenses expressly discussed in the Egg Donor Contract between myself and prospective Intended Parents.

I agree and understand that I must provide some or all required documentation in order to be considered for "Exceptional Donor" status. This documentation includes but is not limited to SAT or ACT scores, college transcripts, I.Q. test results, copy of college diploma or medical diploma, etc. This documentation must be received within three (3) months of applying with Fertility Alternatives, Inc.

I agree and understand that it may be necessary to provide additional photos and/or other non-identifying information requested by potential egg recipients in a reasonable time frame, so they can make a more informed decision.

I understand that egg donation and its processes are time sensitive and require the utmost care, commitment, maturity and flexibility.

I understand that I must attend all appointments scheduled by the attending physician.

I understand that I must take all medication as prescribed by the attending physician in a timely manner.

I understand that I may withdraw from Fertility Alternatives, Inc. Egg Donor Program at anytime **prior** to the medical and/or psychological screening process or after the Egg retrieval procedure without penalty. I also understand that Fertility Alternatives, Inc., has the absolute right to accept or reject my egg donor application, for any reason. In addition, I may be removed from the Egg Donor Program for any reason, more specifically due to reoccurring unavailability, lack of responsiveness on my part, untruthful information in my application, failure to provide requested additional information and/or photos, concurrent enrollment in other egg donor programs, and/or committing unethical practices. I understand that if **after** I am chosen by Intended Parents **and** medically and psychologically screened, **and** I withdraw from the Egg Donor program without good reason (i.e. Severe illness or death in the family, health problems, etc), I will be responsible for returning all fees paid to professionals for my medical and psychological screening to the Intended Parents and/or Fertility Alternatives, Inc. This can be in excess of \$2500.00.

I understand that withdrawal from the Egg Donor Program is defined by, but not limited to, missing three (3) or more appointments with any medical or psychological professional that have not been rescheduled in an appropriate time frame necessary to

continue the cycle, failing to administer medications correctly or as prescribed by the acting physician, providing inaccurate personal information, such as name, address, and phone number, failing to update personal information within a reasonable time period, or any verbal or written withdrawal by me, the Egg Donor, that has not been considered a “good reason”.

I agree that I shall be ultimately responsible to ask IVF physician to explain the medical and psychological risks of the egg retrieval procedure and agree to assume those risks.

I agree to hold harmless Fertility Alternatives, Inc., and all agents for any medical, psychological, or legal complications or problems, either long-term, short-term or permanent, directly or indirectly resulting from the process of egg donation. I take full responsibility for my decision to become an egg donor and assume all risks that may or may not exist.

I agree to waive any claims against Fertility Alternatives, Inc. and its agents from any medical, psychological, legal or other harm that may occur to me as an Egg Donor as a result of participating in the Egg Donor program. This provision in no way is intended to limit the professional negligence of any involved physician or other medical professional.

I understand that Fertility Alternatives, Inc. will provide me with legal professional referrals for counsel during the contract phases of the Egg Donation procedure. Fertility Alternatives, Inc. is not a Party to the Egg Donor Contract between myself and any potential recipients. I agree and understand that Fertility Alternatives, Inc. nor its agents or employees, can offer legal advice with respect to the Egg Donor Contract other than provide information on industry standard. Nor can Fertility Alternatives, Inc. offer any tax advice with respect to compensation earned as an egg donor. It is recommended that I collect advise from a professional tax preparer.

I understand that I am fully responsible for discussing all contract terms with my chosen attorney so that I may have a full and complete understanding of the Egg Donor Contract between myself and potential recipients. I understand, that if I am married, that my husband will be required to be a Party to the Egg Donor Contract, and sign it accordingly.

I understand that the legal fees for such representation will be paid by the Egg/Ovum recipients.

**I hereby authorize the release of my information to Fertility Alternatives, Inc.  
This includes, but is not limited to:**

- 1) Any medical, hospital, clinic, rehabilitation facility, psychiatrist, psychologist, psychotherapist, or other medical practitioner or provider who has or will be providing services regarding my medical and psychological history, treatment, diagnosis and;
- 2) Any firm, employer, agency, or association, whether private, public, or governmental, to furnish information about my background, medical, or any other information, in their possession to: Fertility Alternatives, Inc., or any medical, psychological or legal practitioner provided or retained by said persons, her agents, employees or representatives, if required.
- 3) Arranging for, approving and consenting to any medical, therapeutic or other procedures necessary for the use and preservation of my genetic materials. This authority to include the power to assume full custody and control of these materials for the purpose of removal and relocation to another facility, and/or to assume full custody and control of

all medical records, if needed.

I authorize and permit Fertility Alternatives, Inc., to release the information contained in my Egg Donor Application and/or any other non-identifying information deemed necessary by this Authorization to Receive and/or Release Medical, Psychological, and Other non-identifying Information, to the Intended Parents/potential egg recipients, and their chosen medical facility.

This Authorization is valid from the date signed, until written notice of withdrawal is received Fertility Alternatives, Inc. I understand that a photocopy of this Authorization is equally valid to the original. A copy of this form will be provided to me upon my written request.

**Egg Donor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Husband's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_