

GESTATIONAL CARRIER APPLICATION

ALL INFORMATION ON THIS APPLICATION WILL BE KEPT **CONFIDENTIAL**; HOWEVER, THIS INFORMATION WILL BE SHOWN TO THE INTENDED PARENTS, PSYCHOLOGISTS, AND PHYSICIANS.

Name: _____

Street address: _____

City, State, ZIP: _____

Home phone: _____ Cell: _____

Work phone: _____ Fax: _____

E-mail address: _____

SSN: _____ Date of birth: ___/___/___

Occupation: _____ Length of employment: _____

Employer's name: _____

Employer's address: _____

Height: _____ Weight: _____

Race/ethnic background:

____ Caucasian ____ African-American ____ Asian ____ Latin-American ____ Other

Are you a U.S. citizen? Yes ____ No ____

What is your marital status? Married ____ Single ____ Divorced ____ Widowed ____ Engaged ____
Separated ____

How long have you been married? _____

Name of husband/partner: _____

Date of birth: ___/___/___

Do you live together? Yes _____ No _____ How long? _____

Do you have children together? Yes _____ No _____

Names	Ages	Sex

Are the children biologically related to your husband or partner?

Yes _____ No _____

Would you like to have more children in the future?

If divorced, when did it occur?

Religious background (if applicable): _____

Do you practice? Yes _____ No _____

Do you have a preference of the religious background of the Intended Parents: _____

Would you be willing with to work with :

(please circle one)

- | | | |
|-------------------------------|-----|----|
| A couple with children | Yes | No |
| A couple using an egg donor | Yes | No |
| A couple using an sperm donor | Yes | No |
| A same sex couple | Yes | No |
| Single male | Yes | No |

Single female	Yes	No
An Older couple	Yes	No
An African-American couple	Yes	No
A Jewish couple	Yes	No
A Caucasian couple	Yes	No
An Indian Couple	Yes	No
A Hispanic Couple	Yes	No
An international couple	Yes	No
A couple needing a translator	Yes	No

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

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:

NOTE: We are unable to represent surrogates who are listed with another agency. To be listed with Rocky Mountain Surrogacy, LLC, you will need to terminate your contract in writing through letter or e-mail to be considered. Please send us a copy.

HEALTH INFORMATION

NOTE: Many clinics will require you to send your labor and delivery records from the hospital and your prenatal records from your OB/GYN for all births. Please start gathering those records now.

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____

Please list all allergies:

Do you have any medical problems? Yes____ No____

If yes, please explain:

Number of pregnancies: _____ Live births: _____ Miscarriages: _____

#	Delivery Date	Sex	Birth Weight	# of week Pregnant @ delivery	Type of pain med used
1					
2					
3					
4					

Number of abortions: _____

Date of each abortion: _____

Are you menstrual periods regular? Yes _____ No _____

How long is your cycle? _____

Do you have any bleeding between periods? Yes _____ No _____

How would you describe any cramping you have during your period?

Is there anything unusual about your monthly cycle? Yes _____ No _____

If yes, please explain:

How many days does your period last? _____

Were your children conceived naturally _____ or with medication intervention _____

Are you currently using birth control? Yes _____ No _____

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

Do you smoke cigarettes? Yes _____ No _____ If so, how often? _____

Does any member of your family smoke cigarettes? Yes _____ No _____

If so, who and how often?

Do you drink alcohol? Yes _____ No _____ If yes, how often? _____

Have you ever used illegal drugs or unprescribed drugs? Yes _____ No _____

If yes, what drugs and how often?

Has your husband/partner used illegal drugs or unprescribed drugs? Yes _____ No _____

If yes, what drugs and how often?

Do you have a history of any eating disorders? Yes _____ No _____

If yes, please explain:

Would you be willing to undergo amniocentesis or other diagnostic testing to determine the presence of birth defects? Yes _____ No _____

If there were a serious problem with the fetus and the intended parents wanted to abort, would you be willing to abort? Yes _____ No _____

Are there any specific conditions in which you would not abort a pregnancy? Yes ____ No ____

If yes, please explain:

Have you ever had surgery? Yes ____ No ____

If yes, reasons and results:

List all serious illnesses and hospitalizations:

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

Have you gotten a tattoo or body piercing within the last year and a half? Yes ____ No ____

Have you ever been seen by a professional for mental issues? Yes ____ No ____

If yes, please explain and list time periods:

Have you ever experienced any post-partum depression? Yes ___ No ___

If yes, please give the details and time periods:

Have you ever been prescribed or taken any medications for mental health? Yes ___ No ___

If yes, please list the medications, reasons and time periods:

Have you ever had any problems with drug or alcohol abuse? Yes ___ No ___

If any of your children are deceased, what was the age and cause of death?

Blood type: RH factor _____ Positive ___ Negative ___

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:

Number of months between stopping birth control and conception: _____

Have you ever been seen by a doctor for infertility? Yes _____ No _____

Did your mother take DES while pregnant? Yes _____ No _____

Have you ever been told that you were infertile? Yes _____ No _____

Have you delivered any children with birth defects? Yes _____ No _____

Have your parents had any serious mental or physical illnesses? Yes _____ No _____

If either of your parents are deceased, what was their age and cause of death?

SEXUAL HISTORY

List any contraceptives you have used in the past and any reaction you had to their use:

Which method do you currently use?

Are you with a sexual partner now? Yes _____ No _____

Which method does your partner currently use? _____

Do you currently have more than one sexual partner? Yes _____ No _____

How many sexual partners have you had in the past 3 years? _____

To your knowledge, have you or any of your sexual partners been sexually active with anyone in a high risk group for A.I.D.S.? Yes _____ No _____ If yes, please explain _____

Are you at risk for A.I.D.S.? Yes _____ No _____

Have you ever used IV Drugs? Yes _____ No _____

Have you ever received a blood transfusion? Yes _____ No _____

Have you ever had a sexually transmitted disease? Yes _____ No _____

If yes, please explain:

Please look through the following list of medical problems and indicate which ones you or one of your

relatives have had. Where appropriate, please indicate their relationship to you. For example, if your paternal grandfather had a stroke, put 'PGF' in the box under 'Grandparents' for that condition. Please consider each condition carefully for each member of your family.

	You	Mother	Father	Sibling	Grandparents
Heart					
Stroke					
Heart Attack					
Hardening of the arteries					
Blood					
Anemia					
Sickle Cell anemia					
Hemophilia / other bleeding problem					
Leukemia					
Immune deficiency					
Other blood disorder					
Lungs					
Hay Fever					
Asthma					
Emphysema					
Tuberculosis					
Lung Cancer					
Pneumonia					
Other Lung Disease					
	You	Mother	Father	Sibling	Grandparents
Gastro-Intestinal					

Gall stones					
Hepatitis A					
Hepatitis B					
Other liver disease					
Colon cancer					
Cystic Fibrosis					
Intestinal cancer					
Any other digestive problems					
Endocrine					
Diabetes					
Hypoglycemia					
Thyroid cancer					
Adrenal dysfunction					
Hyperactivity					
	You	Mother	Father	Siblings	Grandparents
Urinary					
Kidney disease					
Chronic UTIs					
Reproductive					
Uterine Fibroids					
Ovarian Cysts					
Cancer of the cervix					
Cancer of the ovaries					
Neurological					
Migraines					
Mental retardation					
Multiple sclerosis					

Cerebral palsy					
Epilepsy					
Mental Health					
Schizophrenia					
Manic depression					
Clinical depression					
Muscle/bones/ joints					
Lupus					

EDUCATIONAL HISTORY

Please choose highest level attained (only choose one):

Completed through grade _____

Graduated high school (GPA _____)

Attended college through (circle one) freshman, sophomore, junior, or senior year

Graduated college

List degrees:

Post-graduate:

Other (trade school, etc.) _____

GENERAL QUESTIONS

Are you receiving food stamps or any other public assistance as part of your income? Yes ____ No ____

Briefly explain your understanding of what being a gestational carrier will entail:

Please describe yourself, i.e., your personality, hobbies, and interests:

What qualities would you consider most important for the intended parents to have?

In the case of a pregnancy with multiples, how do you feel about possibly reducing?

How much contact with or information about the child would you like after birth?

Do you feel confident that you will be able to give the couple the child(ren) you will carry for them?

Yes ____ No ____

Please explain:

What kind of support do you expect for being a gestational carrier from your significant other, siblings, parents, friends, and co-workers? Please explain:

How does your husband/partner feel about your participation in this program? Please describe:

CONSENT

All information provided in this application is true, accurate, complete, and to the best of my knowledge.

Date

Gestational Carrier

I believe my wife's/partner's response to this application is true, accurate, complete, and to the best of her knowledge. I am in support of her desire to become a gestational carrier.

Date

Gestational Carrier's Husband / Partner

I, _____ (the "Gestational Carrier") hereby acknowledge that:

A. Rocky Mountain Surrogacy, LLC did not induce or coerce me in my decision to become a gestational carrier;

B. Rocky Mountain Surrogacy, LLC is not a party to my agreement with the biological mother and/or the biological father;

C. Rocky Mountain Surrogacy, LLC will be providing this application to potential parents both through hard-copy and electronic formats. I acknowledge and agree that I will not be notified of such mailings and hereby consent to the distribution of my application and photos to potential parents via mail and through electronic media such as e-mail.

Therefore, I hereby agree to release and discharge Rocky Mountain Surrogacy, LLC and any of its

representatives, agents, employees and servants from all liability and all manners of action, suits, causes of actions, proceedings, debts, contracts, judgments, damages, claims and demands whatsoever in law or equity in connection with my decision to become a gestational carrier. I also agree to release and discharge Rocky Mountain Surrogacy, LLC from any adverse consequences which may arise in my connection with, or as a result of, my participation in this process. I hereby further agree to indemnify Rocky Mountain Surrogacy, LLC against any and all costs incurred in defending any such actions arising out of this process.

Date

Gestational Carrier

Please mail, e-mail, or fax your completed application, with a photograph of your family, to:

Rocky Mountain Surrogacy, LLC
9965 W. Pettit Ct.
Star, ID 83669

Phone: 208-284-7748

Fax: 541-372-2022

E-mail: tbetts@rockymountainsurrogacy.com