

# GESTATIONAL SURROGACY PROGRAM APPLICATION

Family Formation Law Offices of Diane Michelsen  
3190 Old Tunnel Rd, Lafayette, CA 94549, Tel (925) 945-1880 / Fax (925) 933-6807

**PLEASE  
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COPY OF  
DRIVERS  
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## Personal Identifying Information

Name: \_\_\_\_\_  
Last First Middle

Other Names Known By (Aliases): \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Numbers: \_\_\_\_\_  
Home Cell Work

E-Mail Address: \_\_\_\_\_ Own or Rent? \_\_\_\_\_ How long at address? \_\_\_\_\_

Date & Place of Birth: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ SSN: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Ethnicity (e.g. Irish, Hisp, AA): \_\_\_\_\_ U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Blood Type: \_\_\_\_\_ Religion: \_\_\_\_\_ Marital Status (circle one): Married Single Living Together Divorced Other: \_\_\_\_\_

Did you graduate from high school? \_\_\_\_\_ If yes, what year? \_\_\_\_\_ If no, highest grade completed? \_\_\_\_\_ GED? \_\_\_\_\_

Did you attend college? \_\_\_\_\_ If yes, list: \_\_\_\_\_  
Name City/State Years Attended Degree Major

Employer: \_\_\_\_\_ Current Title: \_\_\_\_\_ How long at current job? \_\_\_\_\_

Work Address: \_\_\_\_\_ Current salary or hourly pay rate: \_\_\_\_\_

## Spouse's / Partner's (circle one) Information (if applicable):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Current Title: \_\_\_\_\_ How long at current job? \_\_\_\_\_

Work Address: \_\_\_\_\_ Current salary or hourly pay rate: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ SSN: \_\_\_\_\_

Names, dates, & places of all marriages and divorces: \_\_\_\_\_

## Legal and Insurance Information:

Please describe any arrests, convictions, sentences, or "run-ins" with the law, including drunk driving (include date and case disposition):

\_\_\_\_\_

\_\_\_\_\_

Are you receiving state aid (e.g. Medi-Cal, CalWORKs, food stamps)? \_\_\_\_\_ If yes, list: \_\_\_\_\_

Do you have insurance? \_\_\_\_\_ If yes, policy name: \_\_\_\_\_ Maternity benefit coverage? \_\_\_\_\_

## Psychological Information:

Have you ever been under the care of a counselor or mental health professional? \_\_\_\_\_ If yes, when? \_\_\_\_\_

For what reason? \_\_\_\_\_ Treatment: \_\_\_\_\_

Have you had any psychiatric hospitalizations? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

Are you (or your children) currently using (or have used in the past 6 months) prescribed drugs for psychiatric reasons (including antidepressants)?  
If yes, please list name(s), dosage, and how often the medication is taken and by whom:  
\_\_\_\_\_

**Medical Information:**

Are you or any family member adopted? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ If yes, for what reason? \_\_\_\_\_

Name and address of current physician: \_\_\_\_\_

Please list any drugs (prescribed / non-prescribed / legal / illegal) you are currently using or have used within the past 6 months:

Name and dosage: \_\_\_\_\_ How often? \_\_\_\_\_

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Do you smoke cigarettes? \_\_\_\_\_ If yes, how much? \_\_\_\_\_ If you previously smoked, when did you quit? \_\_\_\_\_

Does anyone in your household (e.g. spouse, family member, roommate) smoke? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ If yes, how often and how much? \_\_\_\_\_

Have you received any piercings (ears, navel, etc.) and/or tattoos or undergone acupuncture? \_\_\_\_\_ If yes, please list, including date of procedure:  
\_\_\_\_\_

Are your periods regular? \_\_\_\_\_ How long between monthly cycles? \_\_\_\_\_ days. How long does it last? \_\_\_\_\_ days.

Have you ever been a surrogate or donated eggs before? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Birth control presently used: \_\_\_\_\_ Have you ever been told that you have a fertility problem? \_\_\_\_\_

Is there a history of fertility problems (e.g. miscarriages) in your family? \_\_\_\_\_

Have you ever been treated for syphilis, gonorrhea, chlamydia, herpes, venereal warts, HIV, or any other sexually transmitted disease? \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Please complete: Total number of pregnancies: \_\_\_\_\_

Number of live births: \_\_\_\_\_ When: \_\_\_\_\_ Number of still births: \_\_\_\_\_ When: \_\_\_\_\_

Number of abortions: \_\_\_\_\_ When: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ When: \_\_\_\_\_

Did you experience any complications with any pregnancy (e.g. high blood pressure, gestational diabetes, c-section)? \_\_\_\_\_ If yes, describe:  
\_\_\_\_\_

**Children's Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_ In whose custody? \_\_\_\_\_

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Please indicate whether you or any family member had or currently have any of the medical conditions listed below. If yes, please describe.

| MEDICAL CONDITION  | NO | YES<br>SELF | YES<br>RELATIVE | IF YES, DESCRIBE: |
|--|----|-------------|-----------------|-------------------|
| Alcoholism   |    |             |                 |                   |
| Asthma   |    |             |                 |                   |
| Back injury  |    |             |                 |                   |
| Cancer   |    |             |                 |                   |
| Cerebral palsy   |    |             |                 |                   |
| Congenital heart defect  |    |             |                 |                   |
| Crohn's disease  |    |             |                 |                   |
| Cystic fibrosis or diagnosed carrier   |    |             |                 |                   |
| Deafness or other ear problem  |    |             |                 |                   |
| Diabetes   |    |             |                 |                   |
| Disability: mental or physical   |    |             |                 |                   |
| Drug allergy   |    |             |                 |                   |
| Drug usage   |    |             |                 |                   |
| Emphysema  |    |             |                 |                   |
| Endometriosis  |    |             |                 |                   |
| Epilepsy   |    |             |                 |                   |
| Hay fever or other allergy (list)  |    |             |                 |                   |
| Heart attach (coronary)  |    |             |                 |                   |
| Hemophilia   |    |             |                 |                   |
| HIV / AIDS   |    |             |                 |                   |
| Hodgkin's disease  |    |             |                 |                   |
| Huntington's disease   |    |             |                 |                   |
| Hypertension (high blood pressure)   |    |             |                 |                   |
| Kidney disease   |    |             |                 |                   |
| Learning disability  |    |             |                 |                   |
| Manic-Depressive (bi-polar)  |    |             |                 |                   |
| Multiple sclerosis   |    |             |                 |                   |
| Obesity (overweight)   |    |             |                 |                   |
| Schizophrenia  |    |             |                 |                   |
| Seizures or convulsions  |    |             |                 |                   |
| Sickle cell anemia/trait   |    |             |                 |                   |
| Speech problems  |    |             |                 |                   |
| Stroke   |    |             |                 |                   |
| Tay-Sachs Disease  |    |             |                 |                   |
| Thyroid disorder   |    |             |                 |                   |
| Tuberculosis   |    |             |                 |                   |
| Tumors, cysts, nodules, lesions  |    |             |                 |                   |
| Hospitalization, operation, or injury  |    |             |                 |                   |
| Other medical or health problem not listed (including other mental diagnosis): |    |             |                 |                   |

**Your Personal Philosophy (use additional sheet if necessary):**

1. Why do you want to be a surrogate? \_\_\_\_\_
2. Do you foresee any emotional reactions or problems arising from being a surrogate for you or your family? \_\_\_\_\_
3. Who would provide you with emotional support during the process? \_\_\_\_\_
4. If applicable, how does your spouse/partner feel about your participation? \_\_\_\_\_
5. How do you plan to explain your decision to your children? \_\_\_\_\_
6. If you are employed, do you plan to tell your employer? \_\_\_\_\_ Why or why not? \_\_\_\_\_
7. How does your religious belief affect your decision? \_\_\_\_\_
8. How much involvement do you want with the Intended Parents during the pregnancy? \_\_\_\_\_
9. What date will be you be available to begin the process (indicate any dates not available)? \_\_\_\_\_
10. Do you own a car? \_\_\_\_\_ What means of transportation will be available to you for appointments? \_\_\_\_\_
11. Does anyone else live with you? \_\_\_\_\_ If yes, describe your relationship: \_\_\_\_\_
12. Are you currently working with (or registered with) any other surrogacy/egg donor program? \_\_\_\_\_
13. Would you be willing to be medically implanted with embryos created with donated eggs and/or sperm? \_\_\_\_\_
14. Are you willing to carry twins? \_\_\_\_\_
15. If it were determined that you were carrying more than two fetuses and the physician and/or Intended Parents felt that you and/or the fetuses were in jeopardy, would you be willing to undergo selective reduction? \_\_\_\_\_ Why or why not? \_\_\_\_\_  
\_\_\_\_\_
16. If the child you were carrying was determined to have abnormalities (brain or other severe abnormalities: spina bifida, Downe's Syndrome), would you consent to an abortion if requested by Intended Parents or advised by the physician? \_\_\_\_\_ Why or why not? \_\_\_\_\_  
\_\_\_\_\_
17. Under what circumstances would you NOT be agreeable to an abortion? \_\_\_\_\_
18. Is it acceptable for Intended Parents to attend medical appointments with you? \_\_\_\_\_
19. Do you wish post-birth contact (e.g. photos & card the 1<sup>st</sup> year)? \_\_\_\_\_ If yes, describe: \_\_\_\_\_
20. Please indicated in which of the following situations you would participate as a surrogate (please circle answers):

|  |     |    |
|--|-----|----|
| Married Couple .....                                       | Yes | No |
| Single Man: .....  | Yes | No |
| Single Woman: .....  | Yes | No |
| Unmarried Couple: .....                                    | Yes | No |
| Same-Sex Partners: .....                                   | Yes | No |
| Intended Parents of Any Age: .....                         | Yes | No |
| Carrying Child of Other Ethnicity (e.g. Asian, Indian, AA) | Yes | No |

I warrant, under penalty of perjury under the laws of the State of California, that this information is complete and accurate to the best of my knowledge and belief. I understand that any significant misrepresentation or omission is grounds for dismissal from the surrogate program and that I can be held financially responsible for any lab, medical, legal, or psychological costs involved in furtherance of the proposed surrogacy.

Surrogate Applicant's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

Spouse's (Partner's) Signature: \_\_\_\_\_ Dated: \_\_\_\_\_