SURROGATE (GESTATIONAL CARRIER) APPLICATION

Thank you for your interest in applying to become a surrogate with Nurturing Lives.
We greatly appreciate your willingness and efforts to help a family to acheive their dream of a family.
Please take your time to complete this application.

All information on this application will be kept confidential. However some information except from the first page will be presented to the Intended Parents, Psychologists, and the Intended Parent's Physicians.

First Name ___________________ Middle Initial ____________ Last Name ___________________________________

Date of Birth _____________________ Social Security Number _____________________________________

Street Address ____ City ____
State _______________________________ Zip Code ___________________________________
COUNTY in which you live in (not COUNTRY) ____

How long have you lived at the above address? ____

If less than two (2) years, please list prior address(es) for the last two years
Street Address ____ City ____
State _______________________________ Zip Code ___________________________________

Street Address ____ City ____
State _______________________________ Zip Code ___________________________________

Best Phone Number to Reach You ____
Cell Phone Number _______________________ Home Phone Number _______________________________

Name of Emergency Contact Person ____
Emergency Contact Number _____________________________ Relationship _______________________________

Do you have a voicemail, answering machine, or a place where we can leave messages? □ Yes □ No

Email Address ____
Best Time to Contact You ____

General Information

First Name Only ______________________ Age __________ DOB __________ Blood Type __________

Height___'___" (_____ cm) Weight _____ lb (_____ kg) BMI Rh Factor ❒ - ❒ +

Ethnicity ____________ Ancestry ______________ Religion __________ Practicing? ❒ Yes ❒ No

Natural Hair Color ________________ Natural Eye Color ____________

Hair Type ______________________ Complexion ____________________

- Do you speak any other languages other than English? ❒ Yes ❒No Language ____________________
- Current Marital Status ❒ Single ❒ Live-In Boyfriend ❒ Partner ❒ Engaged ❒ Married
- What is your method of transportation? ❒ My car ❒ Will borrow a car ❒ Bus ❒ Uber/Taxi
- If you drive, do you have a valid Driver License and Auto Insurance? ❒ Yes ❒ No
- Are you willing to travel outside of your county of residence if cost is reimbursed? ❒ Yes ❒ No

OB/GYN Information

Menstrual Period

○ How many days does your period last? __________ ○ How many days are in your cycle? ____________________

○ Do you consider your period normal? ◻ Yes ◻ No If no, please describe: ______________________________

○ The flow is: ◻ Light ◻ Moderate ◻ Heavy I change pads/tampons ______ times a day

○ Do you have pain/cramping during your period? ◻ Mild ◻ Moderate ◻ Severe ◻ No

Please describe how you alleviate it: ____

○ Do you have spotting or bleeding between periods? ◻ Yes ◻ No

Contraception

○ Are you currently sexually active? ◻ Yes ◻ No with ◻ Male ◻ Female

○ How many partners have you had in the past 5 years? ____________________

○ Are you currently using birth control? ◻ Yes ◻ No

Method: ________________________ For how long? ____________________ Side effects? ____________________

Reproductive History

Number of biological Children: _____________ # of Vaginal Delivery ____________ # of C-Section ____________

Have you ever had a miscarriage? ◻ Yes ◻ No Please list the dates: ______________________________

Have you ever had an induced abortion? ◻ Yes ◻ No Please list the dates: ______________________________

Have you ever had a stillbirth? ◻ Yes ◻ No Please list the dates: ______________________________

Pregnancy #	Biological (B) or Surrogacy (S)	Vaginal (V) or Cesarean (C)	Date of Delivery	Gender	Weight	Weeks at Birth	Complications

- Did you have any of the following conditions during any of your pregnancies?
  - Pre-Eclampsia - High Blood Pressure ☐ Yes ☐ No
  - Gestational Diabetes ☐ Yes ☐ No
  - Cervical Cerclage for Cervical Insufficiency ☐ Yes ☐ No
  - Uterine/Ovarian Cysts ☐ Yes ☐ No
  - Physican-Ordered Bed Rest ☐ Yes ☐ No
  - Hospitalization other than Labor and Delivery ☐ Yes ☐ No
  - Post-Partum Depressioı ☐ Yes ☐ No

If YES to any of the above questions, please describe: ____________________

○ Do you understand and accept that if you have had any of the above conditions it may prevent you from proceeding as a Surrogate, or you may have to obtain OB medical clearance? ☐ Yes ☐ No

Screenings

○ When was the last time you had an Pap Smear test? ____________ Result: ☐ Normal ☐ Abnormal
Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No When: ____________
If yes, please describe treatment course: ____________________

○ When was the last time you received a Hepatitis B vaccination? ____________
If never, are you willing to receive Hepatitis B vaccination? ☐ Yes ☐ No
If a booster shot is needed, are you willing to receive it? ☐ Yes ☐ No

○ Date of your last HIV/AIDS screening? ____________ Result: ☐ Negative ☐ Positve

- Have you ever been diagnosed with any of the Sexually Transmitted Diseases (STD) below?

Chlamydia	❒ Yes	❒ No	Hepatitis B	❒ Yes	❒ No	Fungal Infection	❒ Yes	❒ No
Genital Herpes	❒ Yes	❒ No	Hepatitis C	❒ Yes	❒ No	Recurrent Vaginitis	❒ Yes	❒ No
Gonorrhea	❒ Yes	❒ No	Syphilis	❒ Yes	❒ No	Yeast Infection	❒ Yes	❒ No
Genital Warts	❒ Yes	❒ No	HIV	❒ Yes	❒ No			

- Has your partner ever been diagnosed with any of the Sexually Transmitted Diseases (STD) below?

Chlamydia	❒ Yes	❒ No	Hepatitis B	❒ Yes	❒ No	Fungal Infection	❒ Yes	❒ No
Genital Herpes	❒ Yes	❒ No	Hepatitis C	❒ Yes	❒ No	Recurrent Vaginitis	❒ Yes	❒ No
Gonorrhea	❒ Yes	❒ No	Syphilis	❒ Yes	❒ No	Yeast Infection	❒ Yes	❒ No
Genital Warts	❒ Yes	❒ No	HIV	❒ Yes	❒ No			

If yes, please list dates and describe treatment course: ____________________

Diet and Medical Information

○ Describe what type of food your regular diet is consisted of:

○ Will you be willing to consume organic food if requested by future Intended Parents which you'll be reimbursed for? ☐ Yes ☐ No
○ Do you drink alcohol? ☐ Yes ☐ No How Often? ____________
○ Do you smoke? ☐ Yes ☐ No How Often? ____________
○ Are you currently taking any medications?
OTC ☐ Yes ☐ No Please list: ____________
Prescription ☐ Yes ☐ No Please list: ____________
○ Please list all food and drug allergies: ____________

○ Have you ever had any surgeries? □ Yes □ No If yes, please list date(s) and procedure(s):

Date	Name of Surgery	Reason	Outcome

○ Do you agree to take any and all medications prescribed by the physician as needed? □ Yes □ No
○ Are you comfortable giving yourself injections? □ Yes □ No
○ You understand that you are required to take daily medications/injections for up to 4 months? □ Yes □ No
○ Do you and your spouse agree to complete all required testing, including STD testing? □ Yes □ No
○ Do you and your partner agree to abstain from sexual intercourse/stimulation as instructed by physician? □ Yes □ No

** Please note that Surrogates and her partner are strongly recommended to complete specific immunizations prior to the Embryo transfer.

Surrogacy Questionnaire

○ What are your thoughts on Surrogacy? Why do you want to be a Surrogate Mother?

___

___

___

○ Is your spouse/partner supporive of Surrogacy? □ Yes □ No
○ Is your immediate family supportive of Surrogacy? □ Yes □ No
○ Are your friends supportive of Surrogacy? □ Yes □ No
○ Who would you consider to be the key support during your Surrogacy Journey?

___

Multiples are very common with Surrogacy. It is the industry standard to place two embryos in the uterus to increase the chance of the positive pregnancy.
Knowing this information , please answer the following:

- Willing to carry a singleton? □ Yes □ No
- Willing to carry twins? □ Yes □ No
- Willing to carry triplets? □ Yes □ No

Termination and Fetal Reduction are sometimes recommended to ensure the safety and health of the surrogate and baby(s). Termination or Fetal Reduction will not be performed because of the sex of the embryo(s). However the physician may recommend it should there be any genetic abnormality.

○ Willing to allow Future Parents the choice to terminate/reduce based on personal choice? □ Yes □ No
○ Willing to terminate/reduce if medically necessary? □ Yes □ No
○ Willing to reduce Triplets to Twins, if medically recommended? □ Yes □ No
○ Willing to reduce Twins to a Singleton, if medically recommended? □ Yes □ No
○ Willing to undergo an Amniocentesis, if medically recommended? □ Yes □ No
○ Willing to undergo an Amniocentesis, if requested by Future Parents? □ Yes □ No
○ Willing to undergo CVS genetic testing/screening, if medically recommended? □ Yes □ No
○ Willing to undergo CVS genetic testing/ screening, if requested by Future Parents? □ Yes □ No

If NO to any of the above, please explain: ___

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Nurturing Lives helps families from all around the globe. If the IPs are international, the Surrogate is not required to travel outside of the USA. The Surrogate must deliver in a Surrogacy Friendly State.
The Surrogate will have the option to receive OB/GYN care at a local facility where the Surrogate resides.

- ● Willing to be matched with Intended Parent(s) reside(s) in the USA? ☐ Yes ☐ No
- ○ Willing to be matched with Intended Parent(s) reside(s) outside of the USA? ☐ Yes ☐ No
- ● Willing to be matched with Intended Parent(s) who require(s) a translator? ☐ Yes ☐ No
- ○ Willing to be matched with Intended Parent(s) with children? ☐ Yes ☐ No
- ● Willing to be matched with Intended Parent(s) with children through surrogacy? ☐ Yes ☐ No
- ○ Willing to be matched with Intended Parent(s) in a Bi-Racial Relationship? ☐ Yes ☐ No
- ● Willing to be matched with Intended Parent(s) in a Homosexual Relationship? ☐ Yes ☐ No
- ○ Willing to be matched with Intended Parent that is single (Gay/Lesbian/Heterosexual)? ☐ Yes ☐ No
- ● Willing to be matched with Intended Parents(s) positive for Hepatitis B? ☐ Yes ☐ No
- ○ Willing to be matched with Intended Parent(s) who are HIV positive? ☐ Yes ☐ No

About You

○ Who will be able to provide child care and to assist with daily tasks in the event of Physician-ordered bed rest?

○ Please describe your personality:

○ What are your hobbies?

○ Please describe one of your normal days.

○ What was the highest level of education you had completed?

○ Please list the person and their age who are living with you:

○ What is your occupation and work schedule?

○ What is your spouse/partner's occupation and work schedule?

○ How would you describe your relationship with your spouse/partner?