DIVISION OF DGA, INC.
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DETAILED APPLICATION FORM

I AM INTERESTED IN BEING AN EGG DONOR ○ SURROGATE MOTHER ○ BOTH ○

Donor (Name): _____

Address_____**City**_____ **State**_____ **Zip code** _____

Phone: Cell:_____ **Home** _____ **Work** _____

Email: Main: _____ **Other** _____

How did you hear about us?

Google ___○___ **Facebook** ___○___ **TV** ___○___ **Print Media** ___○___

Other (Please indicate source) _____

Country of Residence: _____**Age:** _____ **Date of Birth:** _____

Current Occupation: _____ **Prior Occupation:** _____

Height: _____ **Weight:** _____ **Eye Color:** _____

Natural Hair Color: _____ **Natural Hair Texture:** _____

Complexion: _____ **Predominant hand:** _____

Blood group (if certain, otherwise leave blank): _____

Religion: _____ **Are you adopted?** _____

Do you smoke? If so, how many per day: _____

ANCESTRY

Family Member	Ethnicity (East Indian, African, Asian, European, Hispanic, etc)	Country of Birth
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Father		
Mother		

EDUCATION: (Please give full details)

Degree(s) obtained: _____

Did you complete High School? _____

How many years of education have you completed after high school? _____

What did you study? _____

Are you currently enrolled at any educational institution? _____

What are you studying? _____

PERSONAL PROFILE

If you could meet anyone in the world (living or deceased), who would it be and why?

_____

How would you describe your personality and character?

_____

Are you involved in any clubs, hobbies, interests, organizations, sports teams, activities, etc.?

_____

I would describe myself as: _____

I am passionate about: _____

I don't have much time and patience for: _____

Food likes and dislikes: _____

Tell us about your special skills, talents and abilities? (Time to boast!):

_____

What do you do for fun when you have free time?

_____

MEDICAL HISTORY

	No	Yes	When	Details, please
Have you had allergies?	◯	◯		
Have you had any surgeries?	◯	◯		
Are you taking any medications, herbs, supplements?	◯	◯		
Are you currently being treated for any medical conditions?	◯	◯		
Have you ever been under the care of a psychiatrist?	◯	◯		
Do you take any prescription drugs?	◯	◯		

How much and how often do you drink alcohol? _____

Have you ever received treatment for drug and/or alcohol abuse? _____

Please list any significant illnesses you had had and at what age? _____

Do you take any prescription medication? If so, please indicate which ones and the reason:

_____

Are you willing to take health related tests at the expense of the prospective parent(s)?

(Sexual disease, drugs, emotional health, etc.)} _____

Have you ever been tested as a carrier of the following?

	Carrier	Non-Carrier	Not tested
Tay-Sech's disease	☐	☐	☐

Sickle Cell disease	☐	☐	☐
Thalassemia	☐	☐	☐
Cystic Fibrosis	☐	☐	☐

FAMILY HEALTH HISTORY

How many full siblings do you have? _____ What are their ages? _____

Are there any known genetic diseases or conditions that run in your family? _____

Complete the table below: (use natural eye and hair color; fair/medium/dark complexion; small/medium/large frame build)

	Age if living	Age at death	Cause of death	Eye Color	Hair Color	Complexion	Height	Weight
Mother						Select		
Father						Select		
Full Brother(s)						Select		
Full Sister(s)						Select		
Maternal Grandmother						Select		
Maternal Grandfather						Select		
Paternal Grandmother						Select		
Paternal Grandfather						Select		

Have you or any of your immediate family (parents, grandparents, siblings or children) ever had any of the following health issues? If yes, list who had it and at what age.

Health Issue	No	Yes	Parent, Grandparent, Full Sibling or Child	Age of occurrence/Note
Anemia	○	○		
Hemophilia/bleeding disorder	○	○		
HIV/AIDS	○	○		
Asthma	○	○		
Ovarian cysts	○	○		
Endometriosis	○	○		

Migraines	○	○		
Osteoporosis	○	○		
Acne	○	○		
Eczema	○	○		
Allergies/Asthma	○	○		
Emphysema	○	○		
Lung Disease	○	○		
Heart Disease/Attack	○	○		
Hypo or Hyper-Thyroid	○	○		
Chronic Bronchitis	○	○		
Liver Disease	○	○		
Hepatitis	○	○		
Diabetes Type 1 (genetic)	○	○		
Kidney problems	○	○		
Psychological Disorders	○	○		
Epilepsy/Convulsions	○	○		
Multiple Sclerosis	○	○		
Mental Retardation	○	○		
Cerebral Palsy	○	○		
Muscular Dystrophy	○	○		
Cataracts/Glaucoma	○	○		
Blindness or Crossed Eyes	○	○		
Color Blindness	○	○		
Deafness (birth of childhood)	○	○		
Ulcers	○	○		
Cancer	○	○		
Tuberculosis	○	○		
Alzheimer's Disease	○	○		
Cleft Palate/Lip	○	○		
Spina Bifida	○	○		
Down's Syndrome	○	○		
Birth Deformities	○	○		
Stroke	○	○		
Hyperactivity	○	○		
Arthritis	○	○		
Dwarfism	○	○		
Cystic Fibrosis	○	○		
Sickle Cell Disease	○	○		
Thalassemia	○	○		
Alcoholism (if more than two family	○	○		

members)	○	○		
Meningitis	○	○		
High Blood Pressure	○	○		

Communicable Disease Screening

	Question	Yes	No	Don't Know	Comments
1	From 1980 through 1996, did you spend 3 months or more total time in the United Kingdom?	○	○	○	
2	From 1980 through 1996, were you a member of the military, a civilian military employee or a dependent member of the US military?	○	○	○	
3	From 1980 to the present, have you spent time that adds up to five years or more in Europe?	○	○	○	
4	From 1980 to the present, did you receive a blood transfusion in the United Kingdom?	○	○	○	
5	Have you ever been diagnosed with Creutzfeldt-Jacob disease?	○	○	○	
6	Have you ever had a relative diagnosed with Creutzfeldt-Jacob disease?	○	○	○	
7	In the past week, have you had a headache and fever at the same time?	○	○	○	
8	In the past 120 days, have you had a medical diagnosis of West Nile Virus?	○	○	○	
9	In the past 12 months, have you received blood products?	○	○	○	
10	In the past 12 months, have you had sexual contact, even once, with anyone who has hemophilia or has used clotting factor concentrates?	○	○	○	
11	Have you ever taken clotting factor concentrates for a bleeding problem such as hemophilia?	○	○	○	
12	In the past 12 months, have you had an organ or tissue transplant or graft?	○	○	○	
13	From 1980 to the present, have you injected bovine insulin?	○	○	○	
14	Have you received or had intimate contact (e.g. exchanged body fluids, shared toothbrushes and/or razors) with someone who has received organs or cells from non-human sources?	○	○	○	
15	Have you had a recent smallpox vaccination?	○	○	○	
16	Did you have any illness or complications from the vaccine?	○	○	○	
17	In the past 4 weeks, have you had any shots or vaccinations?	○	○	○	
18	In the past 8 weeks, have you had close contact (i.e. sharing kitchen and bathroom) with someone who had a smallpox vaccination?	○	○	○	
19	Did you have any illness or complications from your close contact (i.e. sharing kitchen and bathroom) with someone who had a smallpox vaccination?	○	○	○	
20	In the past 12 months, have you had a tattoo, ear or skin piercing?	○	○	○	
21	Have you ever been diagnosed with or been in contact with someone suspected of having the SARS virus?	○	○	○	
22	Have you been in a place affected by SARS or with an affected person within the past 14 days?	○	○	○	
23	Are you currently taking any medication for infection?	○	○	○	
24	Are you feeling well and healthy today?	○	○	○	

25	Do you currently have an infection, cold, sore throat or cough?	○	○	○	
26	Are you now taking, or have you ever taken any medication(s) listed on the attached medication deferral list?	○	○	○	
27	In the past 12 months, have you had close contact (i.e. sharing kitchen and bathroom) with someone who had yellow jaundice or hepatitis?	○	○	○	
28	In the past 12 months, has your skin been stuck by something that may have been contaminated with blood or body fluids?	○	○	○	
29	In the past 12 months, has someone else's blood been in contact with your open or broken skin or mucous membranes?	○	○	○	
30	In the past 12 months, have you had a positive test or been treated for syphilis, gonorrhea or any other STD?	○	○	○	
31	In the past 12 months, have you been held in jail, prison or any correctional facility for more than 72 hours?	○	○	○	
32	In the past 12 months, have you had sexual contact, even once, with anyone who has HIV/AIDS, Active Hepatitis B or C?	○	○	○	
33	In the past 12 months, have you had sexual contact, even once, with anyone who has taken money, drugs or other payment for sex?	○	○	○	
34	***(Females Only)*** In the past 12 months, have you had sexual contact with a male who had sex, even once, since 1977 with another male?	○	○	○	
35	In the past 12 months, have you had sexual contact, even once, with anyone who has ever used needles to take drugs not prescribed by a doctor?	○	○	○	
36	Since 1977, have you taken money or drugs for sex?	○	○	○	
37	***(Males Only)*** Since 1977, have you had sexual contact, even once, with another male?	○	○	○	
38	Have you ever had malaria?	○	○	○	
39	Have you ever had yellow jaundice (not newborn jaundice), liver disease, hepatitis or a positive test for hepatitis?	○	○	○	
40	Have you ever had a positive test for HIV/AIDS?	○	○	○	
41	Have you ever used a needle, even once, to take drugs not prescribed by a doctor?	○	○	○	
42	Have you ever received human pituitary derived growth hormone or been given any substance of human pituitary origin?	○	○	○	
43	Have you ever received a comea or dura mater (brain covering) transplant?	○	○	○	
44	Have you ever been refused as a blood donor, told not to donate or had problems donating?	○	○	○	
45	Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology?	○	○	○	

Medication Deferral List

Please tell us if you are now taking or have ever taken any of these medications:

☐ **Proscar (finasteride)** - usually given for prostate gland enlargement

☐ **Avodart (dutasteride)** - usually given for prostate enlargement

☐ **Propecia (finasteride)** - usually given for baldness

☐ **Accutane (isotretinoin)** - usually given for severe acne

☐ **Soriatane (acitretin)** - usually given for severe psoriasis

☐ **Tegison (etretinate)** - usually given for severe psoriasis

☐ **Growth Hormone from Human Pituitary Glands** - used only until 1985, usually for children with delayed or impaired growth

☐ **Insulin from Cows (Bovine, or Beef, Insulin)** - used to treat diabetes

☐ **Hepatitis B Immune Globulin** - given following an exposure to Hepatitis B

REPRODUCTIVE HEALTH HISTORY

Please list any reproductive illnesses or disease that you have experienced:

(Please indicate the date(s), complications, outcome, extenuating circumstances, etc.): _____

Have you ever donated eggs? _____ If so, where and when: _____

Have you ever been a surrogate? _____ If so, where, when and result of surrogacy:

_____

Is there a history of twins in your family? _____ Who? _____

Do you have a regular menstrual cycle? _____

Have you ever been pregnant? _____ If so, what was the outcome? _____

Have you had sex? _____ If so what type of birth control are you using? _____

If none, why not? _____

If you could send a message to your prospective recipient, what would it be?

_____

Explain your personal reasons for wanting to be an egg donor and/or surrogate:

_____

Confirmation of Application Information

Under penalty of perjury, I attest that all the information I have provided in my Donor and/or Surrogacy Application is **true**, **to the best of my knowledge**. I confirm that I have thoroughly read, understand, and agree to the information and responsibilities described in the Information and Application Packet. Further, I confirm that I have had all my questions pertaining to egg donation and/or Surrogacy answered and feel that I am fully ready to proceed as an Egg Donor and/or Surrogate. If I am represented by your Agency, I agree to inform its representatives if, at any time, I no longer want to and/or am unable to donate, as well as if I become matched with Prospective Parents for an egg donation via any other means.

Printed Full Name: _____

Signature: _____

Last four digits of Social Security Number: _____

Date: _____

Donor# _____ **(for office use only)**

Signed for Agency: _____

Last four digits of Social Security Number: _____

Date: _____