Donor Application Instructions

Please complete the attached application form and be sure to include all documents requested. Thank you for your interest in participating in our egg donation program. Please review the questions carefully and answer them to the best of your ability.

- Use Blue or Black ink only and write neatly. Please do not use white-out or other correction fluid on your application.

- Please answer all of the questions truthfully and to the best of your ability. An anonymous copy of your application will be given to prospective recipients.

- Sign the Personal History Form and Affidavit Form.

- ***Please attach a recent photograph of yourself***, and copies of the requested documents (see below) to the application. Please note that there might be a delay in processing your application if all of the requested materials aren't received.

Acceptable Forms of Identification

US Citizens:
- Photocopy of your Social Security card, or State Tax Id or copy of your W2 form
- Copy of a valid Photo Id (i.e., driver's license or passport)

For Resident Aliens:
- Photocopy of Social Security Card of Tax ID or W2 form
- Copy of your valid Green Card

For Non-Resident Aliens:
- Photocopy of Social Security Card, Tax ID or W2 form
- Copy of a valid visa

Returning the Application

Please mail the completed packet to:

Genesis Fertility
Attn: Donor Egg Coordinator
6010 Bay Parkway
5th floor
Brooklyn, NY 11204

If you prefer, you can fax the application to 718-283-6580, or email it to donors@genesisfertility.com

Once received, your application will be screened by our medical team. You will be contacted, either through mail or by phone, within one month of receipt of application.

Personal Information

(For internal purposes only; will not be shared with prospective recipients)

Name: _____ Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email:_____ Social Security or Tax ID: _____

Do you have medical insurance? ( ) No ( ) Yes - Insurance Company: _____

Are you a U.S. Citizen? ( ) Yes ( ) No – Country of Birth: _____

Are you a resident Alien with a green card? ( ) No ( ) Yes – Alien Number: _____

Are you a non-resident Alien? ( ) No ( ) Yes – What type of Visa? _____

Visa Number: _____ Expiration Date: _____

Work Permit Number (if applicable): _____

How did you learn about our program? _____
(Please indicate the exact magazine, newspaper or website).

I, _____ have read the Egg Donation information. I hereby acknowledge that all information provided on this Egg Donation Personal History Form has been answered truthfully and to the best of my knowledge.

Signature: _____ Date:_____

Thank you for your time and your interest in being an egg donor!

Office use only:

Date Received: _____ By: _____

OOCYTE DONOR SCREENING FORM

Age: _____ Date of Birth: _____ Marital Status: _____

Height: _____ Weight: _____

Race: _____ Ethnic Background: _____

Physical Characteristics: (Please check appropriate responses)

Body Type/Bone Structure:	( ) Small	( ) Medium	( ) Large	
Eye Color:	( ) Brown	( ) Blue	( ) Green	( ) Hazel
Handedness:	( ) Right	( ) Left	( ) Ambidextrous	

Hair

Hair Color as a Child	( ) Blonde	( ) Brown	( ) Red	( ) Black
Hair Color as an Adult	( ) Blonde	( ) Brown	( ) Red	( ) Black
Shade	( ) Light	( ) Medium	( ) Dark	
Type	( ) Straight	( ) Wavy	( ) Curly	
Fullness	( ) Thin	( ) Medium	( ) Thick	
Texture	( ) Fine	( ) Medium	( ) Coarse	

Skin

Tone	( ) Fair	( ) Light	( ) Medium	( ) Olive
	( ) Light Brown	( ) Dark Brown	( ) Ebony	( ) Rosy
Condition:	( ) Oily	( ) Medium	( ) Dry	( ) Combination
Acne:	( ) None	( ) Slight	( ) Medium	( ) Severe

At what age: _____ Treatment Required? _____

Facial Features

Moles:	( ) None	( ) One	( ) Several	( ) Numerous
Freckles:	( ) None	( ) One	( ) Several	( ) Numerous
Dimples:	( ) None	( ) One	( ) Several	( ) Numerous

Eye Sight

Vision:	( ) Normal	( ) Near-sighted	( ) Far-sighted	
Correction:	( ) None	( ) Glasses	( ) Bifocals	( ) Contacts
	( ) For reading	( ) Lasix		

At what age were they prescribed: _____

Hearing

Any hearing difficulties? ( ) Yes ( ) No

If yes, please describe: _____

Dental

Device: ( ) None ( ) Braces ( ) Retainer

Reason for Device: ( ) Cosmetic ( ) Accident ( ) Disease

Ages used: _____

Family Characteristics

	Eye Color	Hair Color	Skin Complexion	Height	Weight	Body Type	Education Level	Occupation
Father								
Mother								
Brother 1								
2								
3								
4								
Sister 1								
2								
3								
4								
Children 1								
2								
3								
4								

Education and Professional History

Completed High School? ( ) Yes ( ) No

Completed College? ( ) No
( ) Not yet; pursuing degree in _____
( ) Yes; degree in _____

Advanced Degree? ( ) No

(Masters, JD, PhD, etc…) ( ) Not yet; pursuing degree in _____
( ) Yes; degree in _____

What was your favorite subject?

_____

Least favorite subject?

_____

What languages do you speak/read/write?

_____

Please list any educational awards or acknowledgements received:

_____

Please list any volunteer activities or community service:

_____

_____

Please describe any goals/ambitions you have:

_____

_____

Current Occupation: _____ Years: _____

Previous employment: _____ Years: _____

_____ Years: _____

Personal Characteristics

Athletic Ability

( ) Athletic ( ) Active ( ) Average ( ) Inactive

What physical activities do you regularly participate or excel in?

_____

_____

Manual Dexterity

( ) Dexterous ( ) Average ( ) Clumsy

What manual skills do you have?

_____

Musical Ability

( ) Musical ( ) Average ( ) Tone Deaf

Do you play any musical instruments?

_____

Temperament/Personality

What is your favorite food? _____

What is your favorite color? _____

Where would you most like to travel to, and why?

_____

_____

How would you describe your personality (outgoing, shy, funny, etc…)?

_____

_____

What other skills, talents or hobbies do you have?

_____

_____

What is your motivation for becoming an egg donor?

_____

_____

_____

_____

_____

_____

What would you like to tell potential recipients about yourself?

_____

_____

_____

_____

Religion

What religion did you belong to as a child? _____

As an adult? _____

How religious are you now? ( ) Very ( ) Moderately ( ) Somewhat ( ) Not at all

	Mother	Father
Ethnic Origin		
Place of Birth		
Religion Born Into		
Religion Practiced		

Reproductive History

Age at first period: _____

Are your cycles: ( ) Regular ( ) Irregular

Interval between periods: _____ days

Have you had a diagnosis of any gynecological problems (ie; endometriosis, PCOS, abnormal Pap smears, etc.)? ( ) Yes ( ) No

If yes, please describe: _____

Have you or a partner ever been diagnosed with a sexually transmitted infection (ie; Chlamydia, gonorrhea, syphilis, herpes, trichomonas, etc.)? ( ) Yes ( ) No

If yes, please describe: _____

Have you donated eggs before? ( ) yes ( ) no

If yes, how many times?_____

Where was your donation(s)? _____

When was your last donation?_____

Do you know how many eggs were retrieved? ( ) yes ( ) no

If yes, how many? _____

Do you know the outcome of your donation? _____

PREGNANCY HISTORY		
Year/Age	Outcome	Complications

	Yes	No
Did your mother take DES while she was pregnant with you?		
Have you ever been told you are infertile?		
Is there a history of infertility in your family?		
Have you been sexually active during the past six months?		
Are you currently sexually active? How many sexual partners have you had in the past six months? _____		
Are you currently in a monogamous relationship?		
Are you currently or have you taken birth control? If yes, what brand _____ when _____		
Do you use other forms of birth control and, if yes, what type(s)_____		
Have you had more than 10 sexual partners?		
Have you ever had a sexual partner who was gay or bisexual?		

Have you ever had sexual relations with anyone suspected or known to be HIV positive?		
Have you ever had relations with a man who has engaged in anal intercourse or oral sex with another man?		
Have you been exposed to radiation or toxic chemicals in your work or personal life (i.e., lead, mercury, gold)?		

Medical History

Do you have any medical illnesses (i.e., asthma, diabetes, seizure disorders, tuberculosis, etc)?

_____

_____

_____

Have you ever had surgery? Please describe:

_____

_____

List current allergies (food, pollen, bee stings, medications, etc.)

_____

_____

Describe any childhood allergies you've outgrown:

_____

List all drugs, including physician prescribed and non-prescription (please include vitamins and herbs) that you are currently taking:

_____

_____

List any other medications you've taken in the last five years:

_____

_____

Have you ever had a blood transfusion? ( ) Yes ( ) No

Have you ever been refused as a blood donor? ( ) Yes ( ) No

If yes, why? _____

Have you been exposed to radiation or toxic chemicals in your work or personal life (ie; lead, mercury, gold)? ( ) Yes ( ) No

Have you ever had any of the following?

Unexplained weight loss	( ) Yes	( ) No
Kaposi Sarcoma	( ) Yes	( ) No
Fever of unknown origin	( ) Yes	( ) No
Pneumocystic pneumonia	( ) Yes	( ) No

Have you ever had sexual relations with anyone with the above symptoms/diseases? ( ) Yes ( ) No

Do you smoke cigarettes? ( ) Yes ( ) No

If yes, how many per day? _____

Do you drink alcohol? ( ) Yes ( ) No

What types of alcoholic beverages do you drink? _____

How many alcoholic drinks do you consume:

each day? _____

each week? _____

each month? _____

Have you ever used recreational drugs? ( ) Yes ( ) No
(LSD, marijuana, heroin or cocaine, etc.)

If yes, please give details including when last used: _____

_____

Have you ever been treated for depression? ( ) Yes ( ) No

If yes, please describe: _____

Have you ever attempted suicide? ( ) Yes ( ) No

If yes, please describe: _____

	Age	Age at Death	Medical problems or cause of death

Mother			
Father			
Brother 1			
2			
3			
4			
Sister 1			
2			
3			
4			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Your children 1			
2			
3			
4			

Has any member of your family, including yourself, had a birth defect or problem at birth in any of the following body systems? If yes, please explain below.

Bones, muscles, joints, limbs ( ) Yes ( ) No
Gastrointestinal system ( ) Yes ( ) No
Nervous system, brain, spinal cord ( ) Yes ( ) No
Blood or circulatory system ( ) Yes ( ) No
Respiratory system ( ) Yes ( ) No
Genital/Urinary tract ( ) Yes ( ) No
Metabolic (hormones, enzymes, etc) ( ) Yes ( ) No

_____

_____

_____

Birth Defect	Who	When did this happen?	Relevant Circumstances

Do you have any brother or sisters who died in infancy or childhood? ( ) Yes ( ) No

If yes, please explain: _____

Are there any known genetic diseases/conditions that run in your family? ( ) Yes ( ) No

If yes, please explain: _____

Has anyone in your family, including you, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include symptoms that you might not consider serious.) ( ) Yes ( ) No

If yes, please explain: _____

DETAILED FAMILY MEDICAL HISTORY

Please read the following list of medical problems carefully and indicate which ones you or a relative has had. Please consider each condition carefully for each family member and note the age at which the condition appeared:

Medical Problem	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Stroke							
Heart attack							
Heart disease							
Hardening of arteries							
High blood pressure							
Mitral Valve Prolapse							
BLOOD	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding problem							
Leukemia							
Immune deficiency/disease							

HIV/AIDS							
Other blood disorder							
RESPIRATORY	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Cystic fibrosis							
Pneumonia							
Other lung disease							
Gastrointestinal	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Ulcer of stomach/ duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Hepatitis C							
Other liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Intestinal cancer							
Any other cancer or problem of digestive system							
METABOLIC OR ENDOCRINE	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Diabetes Mellitus							
Hypoglycemia							
Thyroid Cancer							
Thyroid disease							

Goiter							
Adrenal dysfunction or disorder							
Hyperactivity							
URINARY	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Kidney disease							
Other disease of urinary tract (urethra, bladder, ureter)							
GENITAL REPRODUCTIVE SYSTEM	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Undescended testicle							
Hypospadias							
Prostate cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix, ovaries or uterus							
Gonorrhea							
Syphilis							
Chlamydia							
Mycoplasma							
Trichomonas							
Pelvic inflammatory disease							
Herpes							
Genital warts							
NEUROLOGICAL	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Migraines							
Mental retardation							
Senility before age 50							
Multiple sclerosis							
Cerebral palsy							

Epilepsy							
Hydrocephalus							
Disorder of the spinal cord							
Huntington's disease							
Gaucher's disease							
Wilson's disease							
Other diseases of the nervous system							
Degenerative neurologic disease							
MENTAL HEALTH	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Mania							
Depression							
Schizophrenia							
Bi-polar disorder							
Anxiety disorder							
Panic attacks							
MUSCULAR/BONES/ JOINTS	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Muscular dystrophy							
Other chronic muscle disease							
Lupus							
Deformity of the spine							
Osteoporosis							
Dwarfism							
Hereditary low back disease							
Arthritis							
Gout							
SIGHT/SOUND/SMELL	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Deafness before age 60							
Deformity of the ear							

Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Deviated septum							
Any sight/sound/smell disorder							
SKIN	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Other disorders of the skin							
OTHER	You	Mother	Father	Siblings	Grand-parents	Other family	Describe
Alcoholism							
Drug abuse, misuse or addiction							
Breast cancer							
Eating disorders							
Malignant disease							
Any other condition not mentioned above							
Learning Disorders (Please specify)							
Attempted Suicide							

DONOR RISK ASSESSMENT QUESTIONNAIRE

Question	Yes	No	Comment
1. Have you injected drugs for a non-medical reason in the last five years, including intravenous, intramuscular and subcutaneous injection?			

2. Have you received human-derived clotting factor concentrates, including factor VIII and/or factor IX concentrate for hemophilia or a related clotting disorder?			
3. In the past five years, have you been given money or drugs in exchange for having sex?			
4. In the past 12 months, have you been in jail for more than 72 consecutive hours?			
5. In the past 12 months, have you had sex with anyone who would answer yes to the previous questions?			
6. In the previous 12 months, have you had sex with a person with known or suspected HIV, hepatitis B or hepatitis C?			
7. In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation (e.g., needle stick) or through contact with an open wound, non-intact skin or mucus membrane?			
8. In the past 12 months have you had an accidental needle stick, sharp instrument injury, contact with human blood, serum or plasma in the eye, mucous membranes (lips or interior of nose) or sores?			
9. In the past 12 months , have you lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection?			
10. In the past 12 months, have you had ear, skin or body piercing, scarification or tattooing?			If no, go to question 11. If yes, go to question 10a.
10a. Did you have a tattoo or scarification in the past 12 months? If so, when?			If no, go to question 10c. If yes, go to question 10b.
10b. Were sterile instruments used?			
10c. Did you have an ear, skin or body piercing performed in the past 12 months? If so, when?			If no, go to question 11. If yes, go to question 10d.
10d. Were sterile instruments used?			
11. Have you had a clinical diagnosis of hepatitis?			

12. Have you, your sexual partner(s) and/or any member of your household ever had a transplant or medical procedure that involved being exposed to live cells, tissue or organs from an animal?			If no, go to question 13. If yes, go to question 12a
12a. If the person referred to in question 12 was a member of your household, were you exposed to that individual's blood, saliva or other body fluids (e.g., through deep kissing, shared toothbrushes, razors, or needles, or through open wounds or sores)?			
13. Have you been suspected to have or diagnosed with West Nile Virus (including diagnosis based on symptoms and/or laboratory results, or confirmed WNV viremia) in the past 120 days?			
14. Within the past 8 weeks, have you had a smallpox vaccination?			If no go to question 15. If yes, go to question 14a.
14a. Did the scab separate/ fall off by itself?			
14b. Did you have any illness or complications from your vaccination?			
15. Within the past 8 weeks, have you had close contact with a smallpox vaccination site of someone else who received the vaccination (examples include touching the site, the bandages covering the site or handling bedding or clothing that has been in contact with an unbandaged vaccination site)?			If no go to question 16. If yes, go to question 15a.
15a. Have you had any new skin rash or sore since the time of contact?			
15b. Have you had any illness or complications from your close contact with someone who was vaccinated?			
15c. Did the scab separate/fall off by itself from the person who had the smallpox vaccination?			
16. Have you ever been treated for or diagnosed with Chlamydia, gonorrhea, herpes simplex type 2 and/or syphilis? If so, when?			
17. Have you or any of your blood relatives been diagnosed with Creutzfeldt-Jakob disease (CJD)?			

18. Have you been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology?			
19. Have you ever received growth hormone made from human pituitary glands?			
20. Have you ever received a non-synthetic dura mater (brain covering) graft			
21. Have you received a bite from an animal suspected for rabies within the last 6 months?			
22. Have you been diagnosed or suspected to have T. Cruzi infection or Chagas disease?			
23. From 1980 through 1996 were you a member if the U.S. military, a civilian military employee or a dependent of a military member or civilian military employee?			If no go to question 24. If yes, go to question 23a.
23a. Did you spend a total of 6 months or more associated with a military base in any of the following countries: Germany, Belgium, or the Netherlands between 1980 and 1990; or Greece, Turkey, Spain, Portugal, or Italy between 1980 and 1996?			
24. Since 1980, have you ever lived in or traveled to Europe (Includes: Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and Yugoslavia)?			If no, please sign below. If yes, go to question 24a.
24a. From the beginning of 1980 through the end of 1996 did you spend time that adds up to 3 months or more in the U.K. (includes England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, and the Falkland Islands)?			
24b. Since 1980, have you received a blood transfusion of blood or blood components in the U.K. or France?			
24c. Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the U.K. between 1980 and 1996)?			

I, _____ have thoroughly read the Risk Assessment Questionnaire. I hereby acknowledge that all information provided on this form has been answered truthfully and to the best of my knowledge.

Signature: _____ Date:_____