IMPORTANT INSTRUCTIONS:
Before filling out this form,
SAVE AS on your Device
Open the SAVED pdf on your device and complete

GESTATIONAL CARRIER APPLICATION

Full Name: _____

Address: _____

_____

Date of Birth: _____ Social Security Number: _____ - _____- _____

Phone: Cell: _____ Home: _____

Email: _____

Are you or is anyone in your household on public assistance (food stamps, etc.) yes☐ no☐

If yes, what type and for how long: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Date of current marriage: _____ Partner's full legal name: _____

If you are not married, are you in a committed relationship: yes☐ no☐

Have you or your spouse had any problems with the law in the past 10 years: yes☐ no☐

If yes, explain and list any arrests, convictions, and sentences:

_____

_____

Please list all states and countries you have lived in the past 10 years:

_____

_____

References: Please list the names, addresses, and phone numbers of three people other than family members who have known you for at least 5 years. Please discuss your participation in our program with them, so when we contact them they will know why we are calling.

1. Name: _____ ☐ ☐ ☐
   Phone Number: _____ Best time to call: AM / PM / ANY
2. Name: _____ ☐ ☐ ☐
   Phone Number: _____ Best time to call: AM / PM / ANY
3. Name: _____ ☐ ☐ ☐
   Phone Number: _____ Best time to call: AM / PM / ANY

Gestational Carrier Information (To be provided to IP)

Name (first name only): _____

City and state of residency: _____

Date of birth: _____ Height: _____ Weight: _____

Have you been a Gestational Carrier before? Yes ☐ No ☐ If yes, how many times? _____

Do you have health insurance in place already? _____

Does it cover surrogacy: Yes ☐ No ☐ (If you do not know, please call and check)

Is there any time you will be out of town in the next 6 months? _____

Have you been or plan on going to Mexico or a similar place where the Zika Virus has been confirmed in the last 6 months or in the future during a pregnancy? Yes ☐ No ☐

Do you have a car? Yes ☐ No ☐

If no, do you have access to a car? Yes ☐ No ☐

Have you or your spouse been charged with any drug related, domestic violence, or child abuse crimes in the past 10 years? (Whether convicted, charges were dropped, or received a withheld judgement) Yes ☐ No ☐

If yes, please explain including date, location, and outcome: _____

_____

_____

Religious background (optional): _____

Are you currently practicing? Yes ☐ No ☐

Are there any individuals or couples that you would choose not to work with?

_____

_____

_____

A NEW BEGINNING surrogacy

Marital Status

Married☐ Single☐ Divorced☐ Separated☐ Widowed☐

Spouse/Partner's name (first only): _____ Age: _____

Occupation of spouse/partner: _____

If not married, are you currently involved in a committed relationship? Yes☐ No☐

Personal Health History

Do you currently have allergies? Yes☐ No☐

If yes, please list the substance and reaction they cause:

_____

_____

_____

How is your diet? _____

Do you have special eating habits (vegetarian, vegan, etc.)? _____

Do you exercise? Yes____ No____

What type of exercise and how often per week? _____

_____

Do you smoke cigarettes? Yes☐ No☐

If yes, how many and how often? _____

Do you drink alcohol? Yes☐ No☐

If yes, how much and how often? _____

When was the last time you used recreational drugs, and which drug(s)? _____

_____

Do you drink caffeinated beverages? Yes☐ No☐

If yes, how much and how often? _____

Are you currently taking any medications prescribed by a physician? Yes☐ No☐

If yes, please list each medication, for what condition, daily dosage, and length of time you have been taking it: _____

_____

Have you ever had major radiation or x-ray exposure? Yes☐ No☐

Have you ever had a blood transfusion? Yes☐ No☐

If yes, when and why? _____

Have you ever been hospitalized? Yes☐ No☐

If yes, when and for what reason?

_____

_____

_____

Do you have any current, chronic medical conditions? Yes☐ No☐

If yes, please explain: _____

_____

Number of pregnancies: _____

Live births: _____ Miscarriages: _____ Abortions: _____

Delivery Date	Sex	Birth Weight	Weeks In Pregnancy	C-Section or Vaginal Delivery?	Type of meds used	Was this a surrogacy pregnancy?

Were there any complications in any of your deliveries? Yes☐ No☐

If yes, please explain: _____

_____

If you have experienced a miscarriage, please state the date and how far along you were: _____

_____

_____

Are your menstrual periods regular? Yes☐ No☐

How would you describe any cramping you experience during your period? _____

_____

Is there anything unusual about your cycle? If so, please explain: _____

_____

Are you currently using birth control? Yes☐ No☐ If yes, what type: _____

Have you ever been told you are infertile? Yes☐ No☐

If yes, when? _____ On what basis? _____

Is there a history of infertility problems in your family? Yes ☐ No☐

If yes, please explain and list their relation to you: _____

_____

_____

Have you ever had an ablation before? Yes☐ No☐

If yes, what type and what for? _____

_____

Do you have a history of eating disorders? Yes☐ No☐

If so, please explain: _____

_____

Please list any surgeries you have had, including the dates:

_____

_____

_____

Have you received any tattoos in the last six months? Yes☐ No☐

Have you been seen by a mental health professional? Yes☐ No☐

If yes, please explain _____

Have you been prescribed or taken any medications from a mental health professional? _____

_____

Have you experienced Post-Partum Depression? Yes☐ No☐

Have you had any problems with drugs or alcohol? Yes☐ No☐

If yes, please explain: _____

Blood Type: _____ Rh Factor: _____

Number of months between stopping birth control and conception: _____

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

If yes, please explain: _____

_____

Surrogacy Specific

Have you ever been a Gestational Carrier before? Yes☐ No☐

If yes, when and where? _____

How many IVF cycles are you willing to undergo to achieve pregnancy? _____

How do you feel about carrying multiples? _____

_____

Would you be willing to undergo an amniocentesis? _____

_____

Would you permit the Intended Parent(s) in the delivery room? Yes☐ No☐

Would you permit the Intended Parent(s) to attend doctor's appointments? Yes☐ No☐

Are you willing to pump or freeze breast milk? Yes☐ No☐

How much involvement would you like the Intended Parent(s) to have during the pregnancy and delivery? _____

_____

_____

_____

A NEW BEGINNING surrogacy

Sexual History

Are you currently sexually active? Yes☐ No☐

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

Have you had a sexually transmitted disease in the last three years? Yes☐ No☐

Educational History

Are you currently enrolled in school? Yes☐ No☐

What is your major? _____

Please check the highest level completed: High School☐ Junior College☐ College☐
Advanced degree in _____

Other (please specify): _____

Are you working? Yes☐ No☐

Your occupation: _____

What are your job duties? _____

_____

Are you required to lift or operate heavy equipment? Yes☐ No☐

If yes, are you able to get a "light load" duty while you are pregnant? Yes☐ No☐

General Questions

Please answer the following questions thoughtfully and completely so that the interested individuals/couples can get to know you better.

Why do you want to be a Gestational Carrier?

Have you been a Gestational Carrier before? If yes, please explain your experience.

Please describe your personality and character traits.

What are your talents, interests, and hobbies?

If you could pass a message on to the couple you will be working with, what would that message be?

If you are married or in a committed relationship, what was your partner's reaction to you wanting to be a Gestational Carrier?

_____

_____

_____

Have you discussed being a Gestational Carrier with your family or friends? If so, what were their reactions?_____

_____

_____

What qualities would you consider most important for Intended Parent(s) to have?

_____

_____

_____

_____

How involved would you like the Intended Parent(s) to be throughout the process?

_____

_____

_____

_____

What type of relationship are you expecting through the process and following the birth?

_____

_____

_____

_____

_____

What types of support systems do you expect to have throughout this process?

_____

_____

_____

_____

Thank you for taking the time to complete this application.

I declare that all of the above information and statements made regarding myself and my family's health history are true and correct. This form has been completed without perjury.

Gestational Carrier Signature: _____

Date: _____

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

Partner's Signature: _____

Date: _____

A NEW BEGINNING surrogacy

Authorization to Release Protective Health Care Information

Patient's Name: _____ SSN: _____

DOB: _____ Phone Number: _____

I hereby consent and authorize _____ (name of health facility) to release to A New Beginning, 8660 W Emerald St, Suite 14, Boise, ID 83704, protected health information concerning any and all OB/GYN history for the above patient. I understand that this information may include, but is not limited to:

Discharge Summary Operative reports Pap Results

History and Physical Anything relevant to previous pregnancy history

The purpose of releasing this information is for the application and approval to be a gestational carrier.

_____ _____

Signature of patient Date

This consent will automatically expire 90 days after the date of signature unless another date has been specified below.

ADDITIONAL IMPORTANT INSTRUCTIONS:
To complete you application - save this document on your device.
Attach completed application to an email to
info@anewbeginningsurrogacy.org