

RECIPIENT INITIAL CONTACT FORM AND
DATABASE ACCESS REQUEST
OVUM DONATION / SURROGACY PROGRAM

Please fill out this form as truthfully and completely as possible. A Database User Name and Password will be emailed to you. Upon receipt of these information, Intended Parent(s) agree not to disclosed any obtained information to a third party without the specific written authorization of Woman to Woman Fertility Center, Inc..

NOTE ON TERMS: As used in this form, “Intended Parent 1” (“IP1”) shall refer to the person who plans to be the legal parent of any child born from the contemplated ovum donation. In the event Intended Parent has a spouse or co-habiting partner, such spouse or partner shall be referred to herein as “Intended Parent 2” (“IP2”).

Date : ____/____/____/
Month Day Year

_____ IP1 Last Name	_____ First Name	_____ Initial	____-____-_____ Social Security Number
_____ IP2 Last Name	_____ First Name	_____ Initial	____-____-_____ Social Security Number

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

Home Address

_____ City	_____ County or Province	_____ State	
_____ Zip code	_____ Country	_____ Home Telephone Number	_____ Home Fax Number

_____ IP1's Work Telephone Number	_____ IP2's Work Telephone Number
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Email Address _____

_____ IP1's Date of Birth	_____ IP1's Place of Birth	_____ Race
_____ IP2's Date of Birth	_____ IP2's Place of Birth	_____ Race
_____ IP1's Occupation	_____ IP2's Occupation	

Please describe your fertility history.

Have you had any previous pregnancies: Yes No

If yes, please explain: _____

Do you have any children: Yes No If yes, ages: ____ ____ ____ and sex: ____ ____ ____

What doctors have you consulted as a result of your infertility?: _____

Did your doctor refer you to Woman to Woman Fertility Center ? Yes No

If not, who referred you ? _____

Have you attempted any of the following options? Adoption ? Yes No

Artificial Insemination ? Yes No In-Vitro Fertilization ? Yes No

Results ? _____

Have you or your spouse been treated for any psychiatric or mental illness? ? Yes No

If yes, please, describe: _____

Are you or your spouse on any prescribed medication? ? Yes No

If yes, please list: _____

Have you or your spouse consulted with a psychologist concerning your desire to have a child thru a third party arrangement? ? Yes No

If yes, who have you consulted : _____

COPY OF DRIVER'S LICENSE AND MARRIAGE CERTIFICATE (IF APPLICABLE) IS REQUIRED, IF YOU ARE NOT A U.S. CITIZEN, COPY OF PASSPORT REQUIRED

In order to facilitate a match please help us to know what is important to you. We will use this information to determine which new applicants to mail to you in the future.

Please rate each of the following characteristics of an ovum donor candidate in order of importance to you. (1 is least important, 10 is most important)

- Marital Status
- Former pregnancies
- Educational background
- Physical Characteristics (hair, eye color, height, weight)
- Family history of physical illness
- Personal characteristics and habits

Other specific information _____

You may complete the form on-line, save it using your name (i.e. smith.pdf), or you may print it and fill it by hand, then

Please mail, email, or fax completed Form and copy of documents to:

**Woman to Woman Fertility Center, Inc.
383 Diablo Road, Suite 100 Danville, CA 94526
Phone (925) 820-9495 Fax (925) 820-3885
Email: wwfc@compuserve.com**