RMA
LONG ISLAND IVF

Egg Donor Application Form

Dear Prospective Donor,

We appreciate your interest in our program. On the following pages, you will find an application and information about egg donation. The process of becoming an egg donor involves a series of psychological and medical screenings. These appointments are made at no cost to you.

- The psychological screening involves approximately 2-3 office visits with our program's social worker.
- The medical screening involves approximately 2 appointments: the first is an ovarian volume (vaginal sonogram and blood testing for hormone levels), and the second is a physical exam which consists of a pelvic exam, drug testing, and blood tests for communicable diseases and genetic disorders.
- Your significant other will also need to see the social worker.

Once your screening is complete, you can be anonymously offered to an intended parent or couple for selection as an egg donor. If you are selected, you will be required to undergo the following:

- Once you begin stimulation for a donor cycle, you will need to come in to one of our monitoring offices between 6:30am-7:45am for blood work and sonograms for approximately 14 days.
- There will also be a day that you will need to come in to RMA Long Island IVF's Ambulatory Care Site, located at our Melville facility, for retrieval (harvesting of eggs). You are given anesthesia via IV sedation for this procedure, and you may resume normal activities the following day. You will need a responsible driver to bring you to the appointment and stay for the procedure.
- We will see you again after your next period for a resolution sonogram to examine your ovaries and uterus.

All donors are compensated $10,000 for the time and effort spent going through a donation cycle. You may be eligible to donate for our program up to six times.

If you are interested in proceeding, complete as much of the following application as you can and return it to us. **Please attach a current photo of yourself for office use only.** Additionally, if you have medical records pertaining to any medical conditions or previous donations, please enclose them. If you are unsure of any of the answers to the family health history questions, we recommend asking your parents and extended family for help. The personal sections help the intended parents sense what kind of person you are and how much thought was given to why you want to donate, so spelling and punctuation are important. **Please do not use white-out to correct mistakes. Instead, draw a line through the error.** You may contact the Egg Donation Team for assistance by calling (631) 768-8714. We will notify you when the review of your application is complete.

Thank you for your interest in helping infertile couples.
Sincerely yours,

Jasmine D'Alessandro, RN
Third Party Manager

Donor Information

Date: _____

Donor's Name: _____

Donor's Maiden Name (if married): _____

Donor's Marital Status: ☐ Single ☐ Married ☐ Engaged ☐ Divorced ☐ Dating ☐ Other

Partner/Husband's Name: _____

Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Donor's Date of Birth: _____ Partner/Husband's Date of Birth: _____

Religion Born Into: _____

Complexion: _____ Eye Color: _____

Hair Color/Type: _____

Children/Ages: _____

Donor's Occupation: _____

Donor Weight: _____ Donor Height: _____

Highest Level of Education: _____

Donor's Medical Insurance Company: _____

Donor's SSN: _____ Partner/Husband's SSN: _____

Donor's Blood Type (if known): _____

Name of Primary Care Physician: _____

May we contact your physician? ☐ Yes ☐ No

Physician's Phone: _____

Physician's Address: _____

Substance Use

Have you ever smoked? ☐ Yes ☐ No

If yes, for how many years? _____ How many cigarettes per day? _____

If you quit smoking, when did you quit? _____

Drug History? ☐ Yes ☐ No | ☐ Current ☐ Past

From when to when? _____

If yes, what types? _____ How often? _____

Alcohol

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, what kind? _____

How many drinks (beer, wine, alcohol) do you consume on average per day? _____

How many drinks (beer, wine, alcohol) do you consume on average per week? _____

How many drinks (beer, wine, alcohol) do you consume on average per month? _____

Have you ever sought help for an alcoholic problem? ☐ Yes ☐ No

If yes, please explain: _____

If you do not drink at all, what is your reason? _____

Allergies

Current allergies? ☐Yes ☐No

If yes, to what? (include drug allergies)_____

How long?_____

Any treatment given?_____

Medications

Drug Name	Dosage	Frequency	Dates Taken	Reason	Current	Past
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Previous Surgery

Date	Type of Surgery	Physician Name

Menstrual History

Age of first menses:_____ Cycle Length:_____ ☐Regular ☐Irregular

Dates last 3 periods started: 1:_____ 2:_____ 3:_____

Describe any menstrual related difficulties since puberty:

How bad were your menstrual cramps as a teenager?_____ Now?_____

Premenstrual Syndrome (PMS)? ☐Yes ☐No

Symptoms, duration, and severity:_____

Describe any medical treatment for menstrual problems:

Reproductive History

Have you ever been pregnant? ☐Yes ☐No

If yes, how many times?_____

If yes, how many stillbirths? _____

How many live births? _____

How many miscarriages? _____

How many abortions? _____

Is there a history of infertility in your family? Explain:

Describe any reproductive complications:

Pregnancy History

Child's Date of Birth	Infertility Therapy (if any)	Miscarriage (D&C done?)	Abortion	Ectopic Pregnancy	C-Section or Vaginal Delivery	Weight and Sex	Pregnancy Complications	Name of Child's Biological Father

Children

Age	Hair Color	Hair Type	Eye Color	Skin Tone

Please be completely candid when answering the following questions. A “yes” response will not necessarily eliminate you as a potential donor. Many applicants have at least one of these conditions. Please answer all questions openly and honestly. The accuracy of the information you provide will have an impact on the future generations you may help to create.

If you are accepted as a donor, a portion of your statements will be made anonymous and then circulated amongst our patients. This information will remain a confidential part of your medical record unless you agree to allow us to share it. If you choose not to share this information with our patients, you will not be allowed to donate with our program.

Are you a citizen of the United States?

☐Yes ☐No

Some people cannot provide a complete family history (including grandparents). For example, if you are adopted, or do not know one side of your family, your ability to provide a complete family history may be compromised. Is there any reason you cannot complete a family history?

☐Yes ☐No
If yes, please explain:

How did you hear about our program? (Please be specific with the publication or website where you saw/ heard our ad, or with the name of the person who referred you.)

Have you ever been an egg donor before?

☐Yes ☐No
If yes, where and how many times?

Please describe any concerns or complications from prior donations:

Personal History Recap

Today's Date: _____ Age: _____ Year of Birth: _____

Religion Born Into: _____ Place of Birth (Country/State): _____

Height: _____ Weight: _____ Race/Ethnicity: _____

Countries of Ancestry: _____

Physical Characteristics

Body Type/ Bone Structure: ☐ Small ☐ Medium ☐ Large

Hands: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Eyes

Color:	☐ Brown	☐ Hazel	☐ Green	☐ Blue
Set:	☐ Narrow	☐ Average	☐ Wide	
Size:	☐ Small	☐ Average	☐ Large	
Shape:	☐ Round	☐ Oval	☐ Almond	
Shade:	☐ Light	☐ Medium	☐ Dark	

Hair

Color as a Young Child:	☐ Blonde	☐ Brown	☐ Black	☐ Red	Other: _____
Natural Color:	☐ Blonde	☐ Brown	☐ Black	☐ Red	Other: _____
Shade:	☐ Light	☐ Medium	☐ Dark		
Type:	☐ Straight	☐ Wavy	☐ Curly		
Fullness:	☐ Thin	☐ Medium	☐ Thick		
Texture:	☐ Fine	☐ Medium	☐ Coarse		

Nose

Size:	☐ Small	☐ Medium	☐ Large
Width:	☐ Narrow	☐ Average	☐ Wide
Length:	☐ Short	☐ Average	☐ Long
Nostril Flare	☐ Small	☐ Average	☐ Wide

Cheekbones

Set:	☐ Low	☐ Average	☐ High
Prominence:	☐ Slight	☐ Medium	☐ Strong

Mouth

Size:	☐ Small	☐ Average	☐ Large
Lips:	☐ Thin	☐ Average	☐ Full

Chin

Shape: ☐ Square ☐ Oval ☐ Round

Prominence: ☐ Slight ☐ Average ☐ Strong

Dimples: ☐ None ☐ Slight ☐ Medium ☐ Strong

Skin

Skin Tone: ☐ Light ☐ Med-light ☐ Medium ☐ Med-dark ☐ Dark

Tanning Ability: ☐ Slight ☐ Medium ☐ Easy

Condition: ☐ Oily ☐ Medium ☐ Dry ☐ Combination

Acne: ☐ None ☐ Slight ☐ Medium ☐ Severe At What Age:_____

Other Facial Features

Moles: ☐ None ☐ One ☐ Several ☐ Numerous Where:_____

Freckles: ☐ None ☐ Several ☐ Moderate ☐ Numerous Where:_____

Dimples: ☐ None ☐ Slight ☐ Medium ☐ Deep Where:_____

Vision Aids

Vision: ☐ Normal ☐ Far-sighted ☐ Near-Sighted

Glasses/ Contacts: ☐ None ☐ Single ☐ Bifocal ☐ Trifocal Age Diagnosed:_____

Laser Corrective Surgery: ☐ Yes ☐ No When:_____

Dental Devices

Device: ☐ None ☐ Braces ☐ Retainer Other:_____

Reason: ☐ Cosmetic ☐ Accident ☐ Disease Other:_____

Age During Use: _____ to _____ years of age

Other Physical Aids

List:_____

Reason/Cause:_____

Religion

Are you an atheist/agnostic? ☐ Yes ☐ No

Religion born into:_____ What religion did you belong to as a child?_____

As an adult?_____

How religious are you now?: ☐ Very ☐ Moderately ☐ Ocasionally Attend ☐ Not at All

Education

Have you completed grade school? ☐Yes ☐No

Have you completed high school? ☐Yes ☐No

Currently in college, pursuing a degree in:_____

Completed college degree in:_____

Currently pursuing an advanced degree in:_____

Completed an advanced degree in:_____

Languages

Speak:_____ Read:_____ Write:_____

Athletic Activity

☐Athletic ☐Active ☐Average ☐Inactive

What physical activities do you engage in?_____

Have you excelled in any physical activities? ☐Yes ☐No

Please list them:_____

Manual Dexterity

☐Dexterous ☐Average ☐Clumsy

What manual skills do you have?

What other skills or talents do you have (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe:

Musical Ability

☐Musical ☐Average ☐Tone Deaf

Work/Occupational History

*(Please DO NOT list employers, or company names; only your occupation/job title)

What were your strengths in school?

What were your weaknesses in school?

Were you ever diagnosed with any learning disabilities?

What is your current or most recent occupation?

What other types of employment have you had?

Describe any weight problems you may have had:

Describe your dietary preferences and dislikes:

Have you ever been convicted of a crime, or at present, have any pending legal action?

☐Yes ☐No If yes, please describe:_____

Describe yourself as a child (e.g., personality, health, interests, activities, etc.):

What are your favorite foods?

What is your favorite color?

Do you like pets? If so, which animal is your favorite?

Where would you most like to travel and why?

How would you describe your personality?

What is your ultimate ambition or goal in life?

What were your reasons for becoming a donor?

What would you especially like your genetic offspring to know about you (if anything)?

Would you be willing to be contacted by RMA Long Island IVF in the future, if your genetic offspring needed further genetic or medical information?

☐Yes ☐No

Family History

Please complete the chart below for each of your immediate family members. Please fill in each family member's current age (or age at death). Please list any medical problems they have currently (and/or their specific cause of death), AND any medical problems they may have had in the past. Be sure to list any brothers or sisters who may have died in infancy. Please ask your family members if you are unsure about their medical history.

Family Member	Age (If Alive)	Medical Problems	Age at Death (If Applicable)	Cause of Death (If Applicable)
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
☐Brother ☐Sister				
☐Brother ☐Sister				
☐Brother ☐Sister				
☐Brother ☐Sister				

What is your ethnic background? (Please check all that apply. If none apply, please write in next to Other:)

☐Northern European (Ireland, Denmark, Finland, UK, etc.)
☐Western European (Austria, France, Germany, etc.)
☐Southern Europe (Italy, Spain, Portugal, etc.)
☐Southeast Asian (Cambodia, Vietnam, etc.)
☐Far East Asian (China, Japan, Philippines, etc.)
☐Middle Eastern (Iran, Israel, Syria, Egypt, etc.)
☐Ashkenazi Jewish / Sephardic Jewish
☐African
☐South American (Brazil, Peru, Argentina, etc)
☐West Indies / Caribbean
☐French Canadian / Cajun
☐Puerto Rican
☐Dominican Republic
☐Mexican
☐Native American
☐Indian
Other:_____

When completing the family history section on the following pages, please DO NOT write the names of your family members or the names of their places of employment (for Occupation: just list their job title/type of employment, for example: office clerk, bank manager, or school teacher, etc.). Please request additional page if needed.

Mother

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe her personality:_____

Father

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his personality:_____

Sibling 1

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

Sibling 2

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

Sibling 3

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

Sibling 4

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

Has any member of your family, including yourself, had a problem or defect AT BIRTH in any of the following body systems?

	Yes	No	Type of Defect	Affected Family Member	Relevant Circumstances
Organ (heart, lung, kidney, etc.)	☐	☐			
Blood circulation	☐	☐			
Respiratory system	☐	☐			
Gastrointestinal system	☐	☐			
Genital/Urinary	☐	☐			
Metabolic (hormones, enzymes, etc.)	☐	☐			
Nervous system, brain, spinal cord	☐	☐			
Bones, muscles, joints, limbs	☐	☐			
Cleft Lip / Cleft Palate	☐	☐			
Other	☐	☐			

Are there any diseases, abnormalities or conditions that appear to run in your family?

☐Yes ☐No

If yes, please indicate the disease(s) and the family members affected:

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious).

☐Yes ☐No

If yes, please explain:

In the following charts, please indicate the number of relatives who have been diagnosed with each condition in the corresponding boxes. **If you have the condition, mark an X under "You." If none of your family members have the condition, you must mark an X under "No One."**

Heart Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-
Heart Disease/ Defect From Birth																		
Other Heart Disease/Defect																		
Heart Attack																		
Hardening of Arteries																		
High Blood Pressure																		
Hypertrophic Idiopathic Subaortic Stenosis (HISS)																		
Other Heart Conditions																		

Blood Conditions

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-
Anemia																		
Leukemia																		
Other Blood Disorders																		

Respiratory Conditions (Lungs)

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-
Hay Fever																		
Asthma																		
Emphysema																		
Tuberculosis																		
Lung Cancer																		
Pneumonia																		
Other Lung Disease																		

Urinary Tract Conditions

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-
Kidney Disease																		
Alport's Syndrome																		
Adult Onset Polycystic Kidney																		
Other Disorders/ Diseases																		

Gastro-Intestinal Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Ulcer of Stomach/ Duodenum																		
Gall Stones																		
Hepatitis A (Infectious)																		
Hepatitis B (Serum)																		
Other Liver Disease																		
Colon Cancer																		
Ulcerative Colitis																		
Crohn's Disease																		
Cystic Fibrosis																		
Intestinal Cancer																		
Hereditary Hypercholesterolemia																		
Familial Colon Polyps																		
Other Disorders/ Diseases																		

Skin Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Acne																		
Eczema																		
Skin Cancer																		
Pigmentation Disorders																		
Melanoma																		
Albinism																		
Neurofibromatosis																		
Other Skin Disorders																		

Genetic Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Hereditary Spherocytosis																		
Sickle-Cell Anemia																		
Hemophilia/Other																		
Fragile X Syndrome																		
Thalassemia																		
Tay Sachs Disease																		
G6DP Deficiency																		
Spinal Muscular Atrophy																		
Other Disorders/ Diseases																		

Genital/Reproductive System Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Prostate Cancer																		
Uterine Fibroids																		
Ovarian Cysts																		
Cancer of Cervix/ Ovaries/Uterus																		
DES Exposure																		
Breast Cancer																		
Infertility Workup																		
Balanced Translocation																		
Other Disorders/ Diseases																		

Metabolic/Endocrine Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Diabetes (Type 2)																		
Hypoglycemia																		
Thyroid Cancer																		
Hyper/Hypo Thyroid																		
Goiter																		
Adrenal Dysfunction/ Disorder																		
Other Disorders/ Diseases																		

Mental Health Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Schizophrenia																		
Bi-Polar/Manic Depression																		
Other Mental Disorders Requiring Hospitalization/ Medications																		
Severe Depression/ Anxiety/Phobias/ Inability to Function																		
Alcoholism																		
Drug Abuse/Misuse/ Addiction																		

Neurological Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Migraines																		
Mental Retardation																		
Senility Before Age 50																		
Alzheimer's Disease																		
Multiple Sclerosis																		
Tuberculosis Sclerosis																		
Cerebral Palsy																		
Amyotrophic Lateral Sclerosis																		
Epilepsy or Seizures																		
Hydrocephalus (Water on Brain)																		
Congenital Hydrocephalus (Aqueduct Obstruction)																		
Huntington's Disease																		
Gaucher's Disease																		
Wilson's Disease																		
Creutzfeldt-Jakob disorder or other neurological disorder																		

Muscle, Bone, and Joint Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Muscular Dystrophy																		
Duchenne-Becker's Muscular Dystrophy																		
Myotonic Dystrophy																		
Autoimmune Disease																		
Lupus																		
Deformity of Spine																		
Osteoperosis																		
Dwarfism																		
Low Back Disease																		
Arthritis: Rheumatoid, Osteo, Other																		
Gout																		
Cleft Palate																		
Cleft Lip																		
Congenital Hip Dislocation																		
Other Disorders/ Diseases																		

Sight, Sound, Smell Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	
Deafness Before Age 60																		
Significant Hearing Loss																		
Deformity of the Ear																		
Cataracts Before Age 50																		
Blindness																		
Color Blindness																		
Glaucoma																		
Deviated Septum																		
Severe Myopia (Poor Vision)																		
Retinitis (Inflamed Retina)																		
Retinoblastoma (Retina Cancer)																		
Retinitis Pigmentosa (Night Blindness, Tunnel Vision)																		
Other Disorders/ Diseases																		

Miscellaneous

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-
Other Cancer Not Mentioned																		
Other Condition Not Mentioned																		

Risk Factor Questionnaire

	Yes	No	Don't Know	Donor Comments	Nurse's Comments
Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection?	☐	☐	☐		
Do you have a clotting disorder for which you have received human-derived clotting factor concentration? Or had sex with anyone who has?	☐	☐	☐		
Have you had sex for drugs or money in the past 5 years?	☐	☐	☐		
In the past 12 months, have you given money or drugs to anyone to have sex with you?	☐	☐	☐		
Have you had sex in the past 12 months with anyone who would answer yes to the above 4 questions?	☐	☐	☐		
In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?	☐	☐	☐		
In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?	☐	☐	☐		
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, contact with an open wound, non-intact skin or mucous membrane?	☐	☐	☐		
In the past 12 months, have you been in close contact or had sex with or shared a kitchen or bathroom with a person having active viral hepatitis?	☐	☐	☐		
In the past 12 months, have you had tattooing, ear or body piercing? If so, please give dates.	☐	☐	☐		
After the age of 11, have you ever had viral hepatitis?	☐	☐	☐		
Have you yourself received or had intimate contact (i.e. exchanged bodily fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?(Xenotransplation)	☐	☐	☐		
Have you had or been in contact with anyone who has had a recent small pox vaccination?	☐	☐	☐		
Have you been diagnosed with West Nile Virus?	☐	☐	☐		
Have you had a headache and a fever within the last 7 days?	☐	☐	☐		
In the past 12 months, have you had acupuncture, electrolysis, an accidental needle stick, or a sharp instrument injury? If so, please give dates.	☐	☐	☐		
Have you ever received growth hormone made from human pituitary glands or any blood products?	☐	☐	☐		
Have you ever received a dura mater (brain covering) bone or skin graft? Give dates.	☐	☐	☐		

	Yes	No	Don't Know	Donor Comments	Nurse's Comments
Have you or your blood relatives ever had Creutzfeldt-Jakob disease or any neurological disease?	☐	☐	☐		
In the past 12 months, have you had a positive syphilis test?	☐	☐	☐		
In the past 12 months, have you had or been treated for syphilis, gonorrhea, or Chlamydia?	☐	☐	☐		
Have you ever been in jail? For how long?	☐	☐	☐		
From 1980 through 1996, were you a member of the US military, a civilian military employee, or a dependent of a member of the US military?	☐	☐	☐		
In the past 3 years, have you ever been outside of the United States? Where and when?	☐	☐	☐		
Since 1980, have you ever lived in or traveled to Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar or the Falkland Islands) Give dates.	☐	☐	☐		
Have you ever been in a place affected by SARS (i.e., China) or been treated or been with an affected person in the past 14 days?	☐	☐	☐		
Were you born in, have you lived in, or have you traveled to any African country since 1977?	☐	☐	☐		
Have you had sexual contact with anyone who was born in or lived in any African country since 1977?	☐	☐	☐		
Have you had a blood transfusion, or were you deferred as a blood donor?	☐	☐	☐		
Have you ever been diagnosed with T.cruzi or Chagas?	☐	☐	☐		
Have you had immunoglobin or Rhogam vaccine? If so, which, and when?	☐	☐	☐		
Have you ever been exposed to toxic substances?	☐	☐	☐		
Does your occupation put you at risk for exposure of radiation?	☐	☐	☐		
In the last six months have you or a sexual partner lived in or travelled to any area affected by Zika? Have you or a sexual partner been diagnosed with Zika Infection in the past 6 months?	☐	☐	☐		
Within the preceding six months, have you been the recipient of a bite from an animal suspected of rabies?	☐	☐	☐		

I have reviewed all risk factor questions and verify my answers to be true:

Donor Signature: _____Date:_____

DE Coordinator Review Signature:_____ Date:_____

Dates: Created 9/9/08 VL
Revised 03/13/20 TS

I, _____, have carefully read and answered all of the questions in this donor egg application. My responses are true and correct to the best of my knowledge. In addition, with the exception of all personally identifying information, I have agreed to allow RMA Long Island IVF, P.C. ("RMA Long Island IVF") to share a portion of this application that contains potentially-identifying information about me (pages 1-13 of this packet, referred to as the "Abstract"), with intended parents. Although the Abstract does not contain my name, date of bith, or address, etc. it may be possible for someone to identify me based on the combination of other information disclosed in the Abstract. I, therefore, waive my rights to privacy under HIPAA and any other pertinent federal and state laws concerning privacy and/or confidentiality. I also hereby release and forever discharge RMA Long Island IVF, its directors, officers and employees from and against any claims stemming from the provision of the Abstract to any intended parents. I further understand that while RMA Long Island IVF will avoid disclosure to every extent possible, intended parents and donors assume the risk of identification via participation in this program.

Potential Donor's Signature _____
Date_____

I hereby authorize RMA Long Island IVF to release to my insurance carrier records pertaining to my medical history, services rendered, or treatment given to me.

Potential Donor's Signature _____
Date_____

If you have any comments or concerns, please feel free to share them with us:

Please save your work and email this completed application as an attachment to **thirdparty@rmaliivf.com**, OR you may print and mail it to:

RMA Long Island IVF Donor Egg Program
8 Corporate Center Drive, Suite 101
Melville, NY 11747

RMA
LONG ISLAND IVF

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