Thank you for your interest in our Egg Donation Program. Our Center is currently seeking women 21-32 years old who are interested in donating oocytes (eggs) to infertile women. Women from all ethnic backgrounds are encouraged to apply. We prefer egg donors to have had at least one child.

Egg donors are either anonymous or known by the recipient. Donors provided by our Center remain anonymous to the recipient. A donor known by the recipient is usually one the recipient has located without our assistance.

Being an egg donor involves several visits to our office, a visit with a clinical psychologist, blood draws, ultrasound examinations of your ovaries, daily injections and ultrasound-guided egg retrieval. If an egg donor is married or in a sexually intimate relationship, the partner is also screened for sexually transmitted diseases.

Egg donors provided by the Center receive $5,000. at their post operative physical exam two weeks after the egg retrieval in compensation for their time. We are required to report compensation paid to donors to the IRS. Donors receiving compensation are required to claim the income (Form 1099-M) with their annual tax return.

The enclosed material describes the program in greater detail. Please complete the screening questionnaire and return it in the stamped self-addressed envelope (enclosed). The consent forms are provided for you to review. Please do not complete the consent form at this time. Should you become an egg donor, a physician will review the contents of the consent form with you before obtaining your signature.

After reviewing your completed questionnaire our Program Coordinator will contact you and possibly make an appointment for an initial consultation.

Again, thank you for your willingness to help another couple have a child. We hope you understand the importance of your participation in the process and the profound appreciation for your help which is expressed by recipients of egg donation.

Sincerely,

Johannah Corselli, Ph.D., H.C.L.D.
Director, Egg Donation Program
OVERVIEW OF THE EGG DONOR SCREENING PROCESS

EGG DONOR CANDIDATES

Candidates for egg donation are women between the ages of 21 and 32 who are healthy and whose parents and grandparents are healthy, free of cancer, heart disease, high blood pressure, high cholesterol and diabetes. Previous fertility in the egg donor is preferred. Employees of the Center for Fertility may not serve as egg donors.

THE SCREENING PROCESS

Screening consists of approximately three to five appointments each requiring an hour or more of time. There are consultations with the Program Coordinator, Clinical Psychologist and Physician. A physical exam is provided, cultures and blood tests are performed. The spouse or intimate partner of an egg donor will also be asked to give blood for testing to rule out sexually transmitted disease. The medical care received is free of charge.

ACCEPTANCE OF EGG DONORS

Applications are first reviewed by our program coordinator, program director and medical director. Applicants with histories compatible with safe and successful egg donation are asked to come in for a clinical interview. In the clinical interview, the family medical and genetic histories are reviewed and your questions and concerns regarding the process can be addressed. We would appreciate it if you could bring a picture of yourself and any children you may have to retain in our files for reference. After the clinical interview you may be accepted as an egg donor on a preliminary basis. It is extremely important to be absolutely honest in completing your application and in answering questions. Any information obtained is highly confidential. Your medical records pertaining to egg donation are located in a high security setting separate from other medical records.

Couples requesting egg donation will be allowed to review a summary of your application for physical characteristics (eye color, hair color, height, weight), medical and genetic history. Information which identifies you will have been removed from the application. Should a couple select you, we will call and ask you to make an appointment with our clinical psychologist. After receiving clearance from the psychologist, appointments will be scheduled for lab work and a physical examination. If the evaluation indicates that undergoing egg donation would be safe for you and factors are favorable for an outcome, arrangements will be made to synchronize the donor and recipient cycles. Birth control pills are commonly prescribed to first gain control of the menstrual cycle.
THE EGG DONATION CYCLE

An approximate date for the egg retrieval will be established based primarily on a time frame acceptable for both the egg donor and recipient couple. In preparation for ovulation induction, the donor will be given injection technique instructions. A friend or spouse may also be trained to give the injections. Lupron (leuprolide acetate) injections will be taken subcutaneously in the thigh area daily for approximately 25 days. Lupron will be taken to suppress release of hormones from the pituitary gland that stimulate the ovaries. The donor will inject a second medication subcutaneously (follicle stimulating hormone, FSH) for 8-12 of the 25 days. FSH is required to stimulate follicle maturation in the ovary. Variations in the medications prescribed will occur depending on what the physician believes is best for you.

The last two weeks of the egg donation cycle when FSH is injected is time intensive. Donors are asked to be at the Center at about 7:30 am nearly every morning in the second week (the week of egg retrieval) for a blood test and ultrasound examination of the ovaries. When the physician determines that the eggs are ready to recover, a third injection is taken (human chorionic gonadotropin, hCG). Egg retrieval will be scheduled in the Fertility Center for about 34-36 hours after the hCG injection. The egg retrieval will take place in the morning and last about an hour. Most women will need about one hour for recuperation in the Fertility Center after egg retrieval. Egg donors must make arrangements for someone else to drive home after the egg retrieval as driving is not allowed.

Payment for your time and inconvenience in the amount of $5,000. will be provided at your post procedure examination two weeks after the egg retrieval. Unfortunately, no compensation is available for cycles which fail to progress to egg retrieval.

WHAT IS NEXT?

If you are still interested in being an egg donor after reading this information, please fill out the screening forms and mail it back to the Center. Your application must be completed in full! After reviewing your application, you will be contacted to inform you of your suitability for egg donation. If you have not been contacted within one month of submitting your application, please call our office at (909) 558-2851 to confirm that your application has been received and is under review.
This screening form is very important to obtain information about you and your family. The information is essential for our evaluation of you as a potential egg donor. The following are guidelines to help you to fill out this form.

1. Please fill in all banks completely. Write "NA" in blanks that are not applicable. Write "UNK" in blanks where you do not know the answer.

2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships such as "first cousin through my mother's sister."

3. Please provide information on all the relatives requested. You do not need to list names.

If you have any questions, please note them and ask them at the time of the next appointment or contact one of the Fertility Center nurses at (909) 558-2851.

Thank you for your cooperation.
EGG DONOR SCREENING FORM

1. Date: __________ SS#: _________________________ Driver’s License #________________

2. Name: ___________________________________________________________________________ Date of Birth __________ Age: _______

3. Current Address: ____________________________________________________________________

4. Home phone number: ___________________ Cell phone: _________________________________

5. Employer: __________________________________________________________________________

6. Employer Phone number: ______________________________________________________________

7. Occupation: __________________________ Education (Years completed): ___________________

8. Do you have health insurance? _____ If yes, give provider: ________________________________

9. Where and when may we contact you: _________________________________________________

10. ABO (Blood) Type: ___________________ Rh: _________________________________

11. Height: _____ Weight: _____ Eye Color: _______ Hair Color _____________________________

12. Ethnic origin of your mother’s family: _________________________________________________

13. Ethnic origin of your father’s family: _________________________________________________

14. Are you adopted?: __________________________________________________________________

15. Do you grant permission to show your picture to the recipient couple?  Yes_____ No_____

YOU WILL BE REQUIRED TO SHOW YOUR DRIVER’S LICENSE OR A VALID FORM OF PICTURE IDENTIFICATION WHEN YOU COME IN FOR AN INTERVIEW. IF YOU HAVE INSURANCE, PLEASE BRING YOUR INSURANCE INFORMATION ALSO.
Please describe your interests and your hobbies:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
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_____________________________________________________________________________________
_____________________________________________________________________________________

Please describe yourself and your personality traits:

_____________________________________________________________________________________
_____________________________________________________________________________________
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Please describe why you are interested in becoming an egg donor:

_____________________________________________________________________________________
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Page 3 of 15
I.D. __________

MEDICAL HISTORY

1. OPERATIONS

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<thead>
<tr>
<th>Year</th>
<th>Type of Operation</th>
<th>City, State</th>
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2. HOSPITALIZATION OTHER THAN SURGERY

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>City, State</th>
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</table>

3. Have you ever had any serious injuries? _______________________________________
   Any broken bones? ________
   If yes, please describe: _______________________________________
   _______________________________________

4. Have you ever had any serious illnesses? _______________________________________
   If yes, please describe and give age of diagnosis: ____________________________
   _______________________________________

Page 4 of 15
5. Are you presently under a physician's care? ______________________________
   If yes, please describe: _____________________________________________
   ________________________________________________________________

6. Current medications or treatments (include over the counter medications).

<table>
<thead>
<tr>
<th>Medication</th>
<th>How Often</th>
<th>Reason</th>
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</table>

7. Do you wear glasses or contact lenses? ________________________________

8. Alcohol use? ____________________________ How much? ____________________________

   If no, have you smoked previously?: ________ How many years? ________________

10. Usual weight: _________ lbs Recent change? ________________________________

11. Allergies (medicines, food, pollens)? ________________________________

12. Are you at risk for human autoimmune deficiency syndrome (AIDS)?
   _____Yes   _____No   _____Don't Know

13. Past or present use of intravenous drugs? _______yes _______no _______don't know

14. Do you have ear and or any other body piercing?       Yes       No
   If yes, when did you have the last piercing done?
   ________________________________

15. Do you have any tattoos? _______yes _______no
   If yes, when did you have the last one done?
   ________________________________
16. Please indicate if you have ever had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>Gonorrhea</td>
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<td>Syphilis</td>
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<td>Herpes</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Hepatitis C</td>
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<td></td>
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<tr>
<td>Blood transfusion</td>
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<tr>
<td>Liver disease</td>
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<tr>
<td>Injuries</td>
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<tr>
<td>Prolonged Fever</td>
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<tr>
<td>Kidney disease</td>
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<tr>
<td>Allergies</td>
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<tr>
<td>AIDS</td>
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<tr>
<td>HIV Positive</td>
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<tr>
<td>Chlamydia</td>
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<tr>
<td>Psychiatric disorders</td>
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<td></td>
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<tr>
<td>Measles</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Fever above 101° or greater in the past 3 months</td>
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</table>

Explain any "yes" answers: ____________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
17. Menstrual History:

- Last menstrual period: ____________
- Usual cycle length: ____________
- Are cycles regular?: ____________
- Age at first period: ____________
- Duration of flow: ____________
- Pain with periods?: ____________

18. Contraceptive History:

- Method(s) Used: __________________
- Year(s) used: __________________
- _____________________________
- _____________________________
- _____________________________
- _____________________________
- _____________________________
- Current contraception?: __________

19. Pregnancy History:

- Total number of pregnancies: ____________
- Dates: ____________
- Number of living children: ____________
- Ages: ____________
- Number of miscarriages: ____________
- Dates: ____________
- Abortions/Gestation Age: ____________
- Dates: ____________

<table>
<thead>
<tr>
<th>Delivery Date</th>
<th>Gestational Age</th>
<th>Place</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
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</table>
20. Sexual History:

   Are you currently sexually active? ________________

   If "yes", are you currently in a monogamous relationship?: ________________

   Total # of partners? ________________  #Partners in last 6 months? ________________

   How long with the current partner? ________________

   Are you homosexual or have you had any homosexual or bisexual relationships?

       ________________ Yes       ________________ No
20. Place a check (✓) in front of any of the following that are a problem for you.

___ Rashes, color change
___ Frequent urinating
___ Chest pain, pleurisy

___ Itching
___ Waking to urinate (#/night)
___ Shaking, tremor

___ Warts, moles
___ Genital sores or discharge
___ TB, or exposure to TB

___ Eczema, lumps, hives
___ Trouble swallowing
___ Weakness, paralysis

___ Very dry skin
___ Poor appetite
___ Fevers, sweats, chills

___ Excessive sweating
___ Gas, Cramps, Pains
___ Numbness, tingling

___ Bleeding or bruising from minor injury
___ Heartburn, Indigestion
___ Pneumonia

___ Anemia
___ Nausea, Vomiting
___ Difficulty walking, coordination

___ Lymph node or gland swelling
___ Constipation, Diarrhea
___ Chest pain, tightness pressure

___ Ear trouble, infection
___ Blood in stool or black stool
___ Poor sleeping

___ Hearing loss, ringing in ears
___ Yellow (jaundice), Hepatitis
___ Fast or irregular heartbeat

___ Eye problems
___ Hemorrhoids
___ Nervousness, tension

___ Nose bleeds
___ Hernia
___ Trouble breathing lying down

___ Stuffy nose, sinus trouble
___ Gall bladder problems
___ Trouble thinking, remembering

___ Hay fever
___ Pains in joints, arthritis
___ Waking short of breath

___ Sore throats
___ Swollen joints
___ Sexual problems

___ Hoarseness
___ Back pain, neck pain
___ Swelling of feet or ankles

___ Dental or gum problems
___ Enlarged or painful breasts
___ Murmurs or rheumatic fever

___ Breast lumps
___ Discharge from nipples
___ Previous heart trouble

___ Shortness of breath
___ Head injury
___ Poor circulation, varicose veins

___ Cough, chest colds
___ Headaches
___ High blood pressure

___ Bringing up sputum with blood
___ Dizziness, fainting
___ Blood clots

___ Wheezing, asthma
___ Convulsions, seizures
___ Cancer

___ Diabetes
___ Minor injury
___ Goiter, thyroid problems

Explain any “Yes” answers: ________________________________________________________________

______________________________________________________________________________________

Page 9 of 15
GENETIC HISTORY

1. ARE THERE ANY KNOWN GENETIC CONDITIONS OR BIRTH DEFECTS IN YOUR FAMILY?
   ______No ______ Yes       If yes, please explain: ________________________________

2. DO YOU HAVE OR HAVE YOU EVER HAD ANY BIRTH DEFECTS? (E.G., HEART DEFECTS,
   CLEFT LIP OR PALATE, CLUB FEET)?
   ______No ______ Yes       If yes, please explain: ________________________________

3. ARE YOU OF JEWISH ANCESTRY? _______Yes _______No _______Unknown

4. ARE YOU OF BLACK ANCESTRY? _______Yes _______No _______Unknown

5. ARE YOU OF MEDITERRANEAN GREEK or ITALIAN/ANCESTRY? _______Yes _______No _______Unknown

6. HAVE YOU EVER BEEN TESTED FOR ANY GENETIC DISEASE SUCH AS:
   Tay-Sachs disease (if of Ashkenazi Jewish ancestry):
   ______ carrier ______ not carrier ______ unknown
   Sickle cell disease (if black ancestry):
   ______ carrier ______ not carrier ______ unknown
   Thalassemia (Italian, Greek, or Oriental ancestry):
   ______ carrier ______ not carrier ______ unknown
   Cystic fibrosis
   ______ carrier ______ not carrier ______ unknown
### GENETIC AND MEDICAL HISTORY

#### CHILDREN (EGG DONOR)

1. **Your children, LIVING:**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Health Problems/Mental Retardation</th>
<th>Age Diagnosed</th>
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2. **Your children, DECEASED:**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Age Diagnosed</th>
<th>Health Problems/Mental Retardation</th>
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### GENETIC AND MEDICAL HISTORY

#### EGG DONOR’S SIBLINGS AND HALF-SIBLINGS

1. **YOUR BROTHERS AND SISTERS, LIVING:**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Health Problem/Mental Retardation</th>
<th>Age Diagnosed</th>
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2. **YOUR BROTHERS AND SISTERS, DECEASED (INCLUDES STILLBORNS, INFANT DEATHS, CHILDHOOD DEATHS):**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age at death</th>
<th>Cause of Death</th>
<th>Age Diagnosed</th>
<th>Health Problems/Mental Retardation</th>
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</table>
## GENETIC AND MEDICAL HISTORY

### FATHER'S FAMILY

1. GRANDFATHER (YOUR FATHER'S FATHER): _____ Living  _____ Dead  
   - Age (or age at death) _____  
   - If dead, cause of death: __________________________  
   - Health Problems/Mental Retardation and Age Diagnosed: __________________________  

2. GRANDMOTHER (YOUR FATHER'S MOTHER): _____ Living  _____ Dead  
   - Age (or age at death) _____  
   - If dead, cause of death: __________________________  
   - Health Problems/Mental Retardation and Age Diagnosed: __________________________  

3. AUNTS AND UNCLES (YOUR FATHER'S BROTHER AND SISTERS), LIVING:
   - **Sex** | **Age** | **Health Problems** | **Age Diagnosed**  
   - 1.  
   - 2.  
   - 3.  
   - 4.  

4. AUNTS AND UNCLES (YOUR FATHER'S BROTHERS AND SISTERS),: DECEASED (INCLUDE STILLBORNS, INFANTS DEATHS, AND CHILDHOOD DEATHS):
   - **Sex** | **Age** | **Cause of Death** | **Age Diagnosed**  
   - 1.  
   - 2.  
   - 3.  
   - 4.  

5. FATHER: _____ Living  _____ Dead  
   - Age (or age at death) _____  
   - If dead, cause of death: __________________________  
   - Health Problem/Mental Retardation and Age Diagnosed: __________________________  

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Page 12 of 15
GENETIC AND MEDICAL HISTORY

MOTHER'S FAMILY

1. GRANDFATHER (YOUR MOTHER'S FATHER): _______Living _______Dead
   Age (or age at death): _______ If dead, cause of death: ________________________________
   Health Problems/Mental Retardation and Age Diagnosed: ________________________________

2. GRANDMOTHER (YOUR MOTHER’S MOTHER): _______Living _______Dead
   Age (or age at death): _______ If dead, cause of death: ________________________________
   Health Problems/Mental Retardation and Age Diagnosed: ________________________________

3. AUNTS AND UNCLES (YOUR MOTHER’S BROTHERS AND SISTERS), LIVING:

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Health Problems/Mental Retardation</th>
<th>Age Diagnosed</th>
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4. AUNTS AND UNCLES (YOUR MOTHER’S BROTHERS AND SISTERS), DECEASED (INCLUDES STILLBORNS, INFANT DEATHS, AND CHILDHOOD DEATHS):

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Age Diagnosed</th>
</tr>
</thead>
<tbody>
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<td>4.</td>
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</table>

5. MOTHER: _______Living _______Dead
   Did your mother have more than one miscarriage? _____Yes _______No _______Don't Know
   Age (or age at death): _______ If dead, cause of death: ________________________________
   Health Problems and Age Diagnosed: ________________________________________________
**MEDICAL AND GENETIC HISTORY**  
**(SPECIFIC CONDITIONS)**

PLEASE INDICATE WITH A CHECK MARK (✓) WHETHER YOU AND/OR YOUR RELATIVE HAVE HAD ANY OF THE FOLLOWING:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If Yes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Seizure Disorder</td>
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<td></td>
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<tr>
<td>2. Muscular Dystrophy</td>
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<tr>
<td>3. Schizophrenia/Manic Depressive Disorder</td>
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<tr>
<td>4. Serious Birth Defects</td>
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<td>5. Cleft Lip and/or Cleft Palate</td>
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<tr>
<td>6. Huntington's Disease</td>
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<td>7. &quot;Open Spine&quot; or &quot;Water on the Brain&quot;</td>
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<td>8. Congenital Heart Defects</td>
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<td>9. Tuberous Sclerosis</td>
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<tr>
<td>10. Diabetes Mellitus</td>
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<td>11. Neurofibromatosis</td>
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<td>12. More Than Five Coffee-Colored Spots on the Skin</td>
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<td>13. Early Death of Heart Attack (&lt;50yo)</td>
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<td>14. Cystic Fibrosis</td>
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<td>15. Severe Bleeding Tendency</td>
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<td>16. Congenital Hip Dislocation</td>
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<td>17. Clubfoot</td>
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<td>18. Hypospadias</td>
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<td>19. Albinism</td>
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<td>20. Hemophilia</td>
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<td>21. High Blood Cholesterol</td>
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<td>22. Asthma</td>
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<td>23. High Blood Pressure</td>
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<td>24. Rheumatoid Arthritis</td>
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<td>25. Polycystic Kidney Disease</td>
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<td>26. Down's Syndrome</td>
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<td>27. Mental Retardation</td>
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<td>28. Premature Senility (Before 60)</td>
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<td>29. Deafness (Before 60)</td>
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<td>30. Blindness in both eyes (Before 60)</td>
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<td>31. Cataracts (Before 60)</td>
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<td>32. Two or more Miscarriages or Stillborn</td>
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<td>33. The same cancer in more than one family member</td>
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<td>34. Alcohol or Drug Abuse</td>
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</table>

IF YES TO ANY OF THESE, PLEASE ANSWER BELOW:

<table>
<thead>
<tr>
<th>QUESTION #</th>
<th>SPECIFIC RELATION</th>
<th>SPECIFIC CONDITION</th>
<th>AGE AFFECTED</th>
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* = Your Parents, Siblings, Children, Aunts, Uncles, Grandparents
EGG DONOR GENETIC AND MEDICAL HISTORY CERTIFICATION

I certify that the information I have provided is to the best of my knowledge a true and complete account of my medical, genetic, and family medical history, under penalty of perjury.

__________________________________________      ____________________________
Egg Donor (Applicant)                              Date

__________________________________________      ____________________________
Witness                                                Date