SPERM DONOR APPLICATION FORM

Date filled out:_____ (MM/DD/YYYY)

To become a sperm donor, we need to learn some information about your personal and medical history. Your responses to these questions will help us to make sure that your health and medical history are compatible with the donation process. This effort will also help us to match you to an appropriate recipient.

Please provide complete and accurate responses to these questions. If you do not know the answer, ask a parent or family member. An anonymous version of this questionnaire will be given to intended parent(s) to facilitate the match.

A "yes" response will not necessarily eliminate you as a potential donor. Most people will have at least one of these conditions in themselves or a family member. The accuracy of the information you will be giving will provide information to potential families you may help to create.

Instructions:

1. **Please fill in all blanks completely.** Please complete all questions and write "N/A" if not applicable.
2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. If you do not know the age, put the approximate age or ask a relative to help you. List exact relationships such as "first cousin through my mother's sister".
3. Please provide information on all the relatives requested. Do not write their names.
4. If you have any questions, please call your donor coordinator.

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____ (mm/dd/yyyy) Place of Birth: _____

Are you a US citizen or permanent resident? ☐ Yes ☐ No

Driver's License #: _____ State: _____

Marital Status: Length of Current Relationship: _____ years

Type of donation I am interested in:

☐ Preferred Donor (Known Donor): Short-term commitment (4-6 weeks per donation). Compensation paid in one lump sum. Intended Parents and Donor agree to "known donor" status and FDA guidelines.

☐ Chosen Donor (Anonymous): 6-8 month commitment. Compensation split to receive 50% after medical clearance and balance after donor has completed final FDA testing – 6 months post donation.

☐ No Preference: Open to either known or anonymous donations.

DEMOGRAPHICS

MAILING ADDRESS:

Street: _____City: _____

State/Province: _____ Zip/ Postal code: _____ Country: _____

OK to leave message?

Home Phone Number: _____ ☐ Yes ☐ No

Work Phone Number: _____ ☐ Yes ☐ No

Cell Phone Number: _____ ☐ Yes ☐ No

Email Address: _____

Do you have medical insurance? ☐ Yes ☐ No

If yes, name of carrier: _____ ID #:_____ Group #_____

Employer: _____

DONATION HISTORY:

Have you applied or been screened to be a sperm donor before? ☐ Yes ☐ No

If yes, list name and location of donor program (s): _____

Have you donated before? ☐ Yes ☐ No If yes, how many times did you donate? ____

Are you currently enrolled as a sperm donor in another program? ☐ Yes ☐ No

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How did you hear about our program?

◯ Radio (which station) _____ ◯ Friend (name) _____

◯ Newspaper (which one) _____ ◯ Magazine (which one) _____

◯ Website (which one) _____ ◯ Other (specify) _____

Did you consult with your family when completing your family medical history? ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Are you currently under a physicians care for any reason? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any major illnesses such as amoebic dysentery (infection of the intestine), hypertension, blood clots, pneumonia, mononucleosis, etc.? ☐ Yes ☐ No

If yes, when? _____

Have you had any serious illness in the past? ☐ Yes ☐ No

If yes, please describe: _____

Have you had any hospitalization(s) not mentioned above? _____

Have you ever been seen by psychiatrist, psychologist, social worker, counselor, or any other mental health professional for any reason? ☐ Yes ☐ No

If yes, when, for how long and for what reason? _____

Have you ever used medications such as anti-anxiety or antidepressants to treat an emotional or psychological problem?

☐ Yes ☐ No

If yes, list why and date last used _____

Have you been vaccinated in the last 6 months? ☐ Yes ☐ No

If yes, what were you vaccinated for? _____

List all medications that you have taken in the proceeding 12 months (prescription):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current over-the-counter medications (include hormones, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, performance-enhancing supplements including steroids, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken anti-malarial drugs or had malaria? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes ☐ No If Yes, when? _____

Have you ever been refused or denied as a blood donor? ☐ Yes ☐ No If Yes, when? _____

Are you eligible to work in the United States? ☐ Yes ☐ No Is your work schedule flexible? ☐ Yes ☐ No

List all the jobs you held in the past five years:

Jobs/Duties	Year Began	Year End

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

If yes, please explain: _____

Have you ever been exposed to “agent orange” or any other herbicides or chemicals (military, forestry, highway service, or elsewhere)? ☐ Yes ☐ No

If yes, which substance(s)? _____

When? _____ Where? _____

In the preceding six months, were you exposed to the following in your job, living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

Exposed to:	Response	When?	How Often?
Toxic Chemicals or Substances	☐ Yes ☐ No		
Sprays	☐ Yes ☐ No		
Fumes/Exhaust	☐ Yes ☐ No		
Radiation	☐ Yes ☐ No		
Flea Powder/Sprays	☐ Yes ☐ No		
Lead/Lead products	☐ Yes ☐ No		
Asbestos/Asbestos products	☐ Yes ☐ No		
Pesticides/Herbicides	☐ Yes ☐ No		
Cleaning solutions/solvents	☐ Yes ☐ No		

Within the past 6 months have you been exposed to UV rays in a tanning booth? ☐ Yes ☐ No

What is your caffeine usage? Number cups of coffee: _____ Soda _____ Tea _____ Energy Drinks _____

Do you currently smoke cigarettes? If yes, how many per day? _____

Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes, how many per day? _____ If no, what year/month did you stop? _____ How many years did you smoke? _____

What best describes your alcohol consumption?

What type of alcohol do you usually consume? ☐ Beer ☐ Wine ☐ Liquor

If you do drink, how many drinks do you usually consume in a week?

Have you ever used recreational or illicit drugs (cocaine, marijuana, LSD, heroin, barbiturates, narcotics, opiates, amphetamines, hallucinogens, tranquilizers, PCP, steroids, or etc.)? ☐ Yes ☐ No

If yes, which one (s) and when did you last use them? _____

Do you sleep well? ☐ Yes ☐ No If no, how do you manage this?_____

Have you had acupuncture, ear and/or body piercing or tattooing in which sterile procedures may not have been used?

☐ Yes ☐ No

Please list and describe all of your tattoos and body piercings:

Date Received:	Description:	Location on Body:	Sterile Needles Used?

Have you ever had any problems with the law (i.e. DUI, custody issues, lawsuits)? ☐ Yes ☐ No

If yes, please explain _____

Please list any arrests, convictions, sentences, etc.: _____

_____

Have you ever been incarcerated? ☐ Yes ☐ No

If yes, please describe: _____

_____

Donor # _____

SEXUAL AND CONTRACEPTIVE HISTORY

Sexual Orientation:

Number of current sexual partners: _____

Number of sexual partners during the last six months: _____

Total number of past sexual partners: _____

In the last 6 months have you had unprotected sex (intercourse without a condom) with a new partner? ☐ Yes ☐ No

Have you ever injected drugs or had a sexual partner who did so? ☐ Yes ☐ No

To your knowledge, have you or any of your sexual partners been in contact with anyone or have you been personally tested or been treated for any of the following:

	N/A	Self	Partner	How many times?	When was the last time?
HIV (Aids)	☐	☐	☐		
NSU (non specific urethritis)	☐	☐	☐		
Syphilis	☐	☐	☐		
Gonorrhea	☐	☐	☐		
Chlamydia	☐	☐	☐		
Trichomonas	☐	☐	☐		
Venereal Warts	☐	☐	☐		
Herpes, Genital	☐	☐	☐		
Viral Hepatitis B or C	☐	☐	☐		
Genital Sores	☐	☐	☐		
Penis Discharge	☐	☐	☐		
Other sexually transmissible diseases	☐	☐	☐		

REPRDUCTIVE HISTORY

FERTILITY HISTORY:

Number of children: _____

Your Children	1	2	3	4
Age				
Sex				
Height/Weight @ birth				
Eye Color				
Frame Size				
Personality				
Artistic Ability				
Intelligence				
Distinguishing Characteristics?				
Wears eye glasses				

PHYSICAL CHARACTERISTICS

Are you adopted? ☐ Yes ☐ No Blood Type if known: _____

Height: _____ Weight: _____

Recent weight loss/gain? ☐ Yes ☐ No If yes _____ lbs loss (or) _____ lbs gain

What was your weight at age 21? _____

Please select response that best describe you below:

Bone Structure:

Complexion: Tan ability:

Skin Condition: Dimples?

Eye Color: Eye set: Eye Size: Shape:

Hair Natural Color: Type: Texture: Fullness:

Baldness: ☐ Yes ☐ No Baldness in Family: ☐ Yes ☐ No

Premature Graying: ☐ Yes ☐ No If yes, at what age_____

Body and Facial Features:

Condition of your teeth:

Have you had any periodontal or orthodontic work? ☐ Yes ☐ No If yes, at what age? _____

Hearing (without corrective aids):

Vision (without corrective lenses): Prescription (If known): _____

PERSONAL HEALTH HISTORY

Do you wear glasses or contacts or have you had laser surgery? ☐ Yes ☐ No

If yes, are/were you: Other (specify):_____

Do you have astigmatism (blurred vision due to an irregularity in the curvature of the cornea.? ☐ Yes ☐ No

If yes, age diagnosed _____

Do you have any Allergies? ☐ Yes ☐ No

If yes, are they to:

Please list any childhood allergies that you have outgrown: _____

For each medication allergy, describe specific substance and reaction(s) and age first noticed:

Substance: _____ Reaction(s):_____

Substance: _____ Reaction(s):_____

Substance: _____ Reaction(s):_____

SOCIAL HISTORY AND HABITS

Religion Born Into: _____ Religion Practiced:_____

Grade Point Average (GPA): _____ SAT Scores: Verbal _____ Math _____ ACT Score: _____

Education:

Currently in college, pursuing degree in _____

Completed college, degree in _____ GPA:_____

Currently pursuing an advanced degree in _____

Completed advanced degree in _____

Did you have any learning disabilities or weaknesses in school? If yes, describe: _____

Academic Strengths (i.e. math, reading):_____

How many languages do you speak? _____Which one (s): _____

Musical Talent or Instrument: _____

SOCIAL HISTORY AND HABITS (continued)

Artistic Talent: _____

Athletic Skills / Favorite Sports: _____

Other skills/hobbies/talents/interests do you have (i.e. writing, reading, ability to do games or crossword puzzles, handcrafts)? Describe: _____

Current Occupation: _____ How long have you been at your current job? _____

HABITS:

Exercise Habits: Type of Exercise: _____

Your diet is: Your diet is:

Do you have any dietary restrictions? _____

FAMILY HEALTH HISTORY

How many blood siblings are in your immediate family (including yourself and half siblings)? _____

Number of Brothers _____ Number of Sisters _____

Number of Maternal Aunts _____ Number of Maternal Uncles _____

Number of Paternal Aunts _____ Number of Paternal Uncles _____

Do you have any brothers or sisters that died in infancy or childhood? ☐ Yes ☐ No

If yes, what was the cause? _____

Are there any members of your family with a history of learning disabilities or autism? ☐ Yes ☐ No

If yes, please explain _____

FAMILY HEALTH HISTORY (continued)

Describe genetic family members according to the following characteristics. Use natural eye and hair color; fair/dark, etc. complexion. If they are deceased, please list cause of death. Please do not put "natural" as a cause of death. If unknown, write "unknown."

	Hair Color	Eye Color	Height - Weight	Skin Tone	Age if Living	Age at Death	Cause of Death
Mother							
Father							
Brother: 1.							
2.							
3.							
4.							
Sister: 1.							
2.							
3.							
4.							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

FAMILY HEALTH HISTORY (continued)

Carefully review the following list of medical problems and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal or paternal), the age at the time of onset, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, please indicate none.

***PLEASE REFER TO THE GLOSSARY FOR DEFINITIONS**

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
CANCER									
Breast									
Colon or Intestinal									
Lung									
Ovarian or Uterine									
Prostate or Testicular									
Skin									
Stomach									
Thyroid									
Blood (e.g. leukemia)									
Other									
HEART									
Stroke									
Heart Attack									
Congenital Heart Disease									
Heart Disease or Defect									
Hardening of the Arteries									
High Blood Pressure									
High cholesterol level									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
BLOOD									
Anemia									
Sickle-Cell Anemia									
Factor V Leiden thrombpphilia (Blood clots or strokes)									
Hemophilia or other Bleeding/Clotting Disorders such as Von Willebrand's Disease									
Immune Deficiency									
Leukemia									
Lymphoma or Swollen Lymph Nodes									
HIV									
Thalassemia									
Polyarteritis Nodosa									
Other Blood Disorder									
RESPIRATORY									
Asthma									
Hay Fever									
Emphysema									
Tuberculosis									
Pneumonia									
Alpha-1 antitrypsin Disorder									
Blood in Sputum									
Other Lung Disease									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
GASTRO-INTESTINAL									
Appendicitis									
Ulcer of Stomach or Duodenum									
Gallstones									
Hepatitis A,B or C									
Cirrhosis of the Liver									
Other Liver Disease									
Ulcerative Colitis									
Crohns Disease									
Pyloric Stenosis									
Multiple Polyps of the Colon									
Rectal Disorder									
Inflammatory Bowel Disease									
Any other problem of the digestive system									
METABOLIC/ ENDOCRINE									
Diabetes requiring insulin therapy									
Diabetes not requiring insulin therapy									
Childhood Diabetes									
Thyroid disorder									
Goiter									
Hypoglycemia									
Adrenal Dysfunction or Disorder									
Phenyl Ketonuria (PKU) or inherited Metabolism Disorder									
Obesity									
Dwarfism									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
NEUROLOGICAL									
Migraines									
Mental retardation									
Senility or Mental Deterioration before age 50									
Multiple Sclerosis									
Cerebral Palsy									
Neurofibromatosis									
Epilepsy / Seizures									
Attention Deficit Disorder/ Hyperactivity									
Autism / Asperger's									
Alzheimer's Disease/Dementia									
Hydrocephalus									
Tuberous Sclerosis									
Parkinson's Disease									
Creutzfeldt-Jakob Disease									
Scoliosis									
Myasthenia Gravis									
Huntington's or Wilson's Disease									
Tourette's syndrome									
Other diseases of the nervous system									
MENTAL HEALTH									
Anxiety / Panic Attacks									
Anorexia / Bulemia/other eating disorders									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Depression									
Schizophrenia									
Manic Depressive or Bipolar Disorder									
Other mental health disorder requiring hospitalization									
Suicide Attempts									
Other mental health problems that warranted counseling (please list)									
MUSCLE/BONE/ JOINTS									
Muscular Dystrophy									
Achondroplasia – form of dwarfism with abnormal bone growth									
Other Chronic Muscle Disease									
Osteogenesis imperfecta (brittle bone disease)									
Loss of Muscle Coordination									
Osteoporosis									
Marfan Syndrome									
Arthritis									
Rheumatoid or Juvenile Arthritis									
Spinal Muscular Atrophy									
Hereditary Low Back Disorder or Deformity of Spine									
Reiter's Disease									
Myasthenia Gravis									
Gout									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Metabolic Bone Disease (be more specific)									
Lupus (systemic lupus erythematosis – SLE)									
SIGHT/SOUND/ SMELL									
Deafness before age 60									
Deformity of the ear									
Cataracts before age 50									
Blindness									
Color Blindness									
Severe Myopia									
Glaucoma									
Retinoblastoma									
Retinitis Pigmentosa									
Deviated Septum									
Any other Sensory Disorder									
SKIN									
Acne									
Albinism									
Eczema									
Excessive Facial Hair (Hirsutism)									
Pigmentation Disorders									
Psoriasis									
Neurofibromatosis									

FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Other disorders of the skin									
Infectious Skin Disease									
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)									
CONGENITAL ABNORMALITIES/ BIRTH DEFECTS									
Cleft Lip / Palate									
Congenital Hip Problems									
Club Feet									
Heart Defect									
Hearing Problems									
Spina Bifida -Neural Tube (open spine)									
Microcephaly									
Holoprosencehpaly – a single-lobed brain structure and severe skull and facial defects									
Other									
CHROMOSOMAL ABNORMALITIES									
Down Syndrome									
Other (i.e. Turner, Fragile X, Klinefelter's etc.)									
OTHER									
Alcoholism									
Drug abuse, Misuse or Addiction									
Premature degeneration of any organ system									

More information about the above medical conditions are located at: http://www.mazornet.com/genetics/index.htm

GENETIC HISTORY

Ethnic origin (e.g., French, Irish, East Indian)

Mother: _____ Father: _____

Race: Note all that apply for your ancestors:

Mother _____ Father _____

Maternal Grandmother _____ Maternal Grandfather _____

Paternal Grandmother _____ Paternal Grandfather _____

Have you or anyone in your family ever been tested positive as a carrier or had any of any of the following:

Blooms Syndrome Canavan

Cystic Fibrosis

Fabry Disease

Familial Dysautonomia

Familial Mediterranean Fever

Fanconi Anemia Grp. C

Gaucher

Niemann-Pick type A

Mucolipidosis type IV

Sickle Cell

Tay-Sachs

Thalassemia

Is there anything else we should know about your family?

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality, temperament, and character:

What physical, artistic, intellectual or social abilities do you feel best about:

What are your present and future career goals:

What are your present and future personal goals:

List the 3 achievements you are most proud of:

PERSONAL AND MOTIVATIONAL (continued)

THIS PAGE WILL BE SHARED AND VIEWED BY RECIPIENTS

What is your favorite movie? _____

What is your favorite book? _____

What is your favorite color? _____

What is your favorite food? _____

What is one of your most memorable moments and why?

If you could change one thing about yourself, what would it be and why?

Is there a person alive or dead whom you admire and why?

What would you do on a “perfect” day if you could do anything you wanted?

Describe your personality and temperament as a child:

What was your favorite thing to do as a child?

PERSONAL AND MOTIVATIONAL (continued)

THIS PAGE WILL BE SHARED AND VIEWED BY RECIPIENTS

What did your parents teach you to value?

How were you in comparison to other children?

Describe your personality and temperament as a teenager:

Did you have any problems as a child and/ or as a teenager? Explain:

Who was the most important influence on you and why?

What were your ambitions/ goals as a teenager?

What were your best and worst subjects in school?

PERSONAL AND MOTIVATIONAL (continued)

Please provide the following information about your family:

	Intellectual/Academic Achievements	Artistic Achievements
Mother		
Father		
Sisters		
Brothers		

Reasons for wanting to donate your sperm:

If you could pass on a message to the recipient(s) of your sperm, what would that message be?

If you could write a message to the child born through your participation as a sperm donor for when he/she turns 18 years old, what would you tell him/her?

FDA Risk Factors	Yes	No	Comments
Have you been exposed to Zika virus in the past 4 weeks?			
Have you travelled to an area where Zika virus has been reported in the past 4 weeks?			
Have you had fever, rash, joint pain, and conjunctivitis (red eyes) in the past 4 weeks?			
Have you had sexual contact with a man/woman diagnosed with or had symptoms suggestive of Zika infection in the 3 months?			
Have you ever been sexually active with a male who was gay or bisexual?			
Have you ever injected drugs or had a sexual partner who did so?			
Have you ever had hemophilia or received any human derived clotting factor concentrates, including factor VIII or factor IX concentrate?			
Have you ever had a sexual partner with hemophilia or who received any human derived clotting factor concentrates?			
Have you ever had sex in exhange for money or drugs?			
Have you ever been sexually active with a person who has had sex in exchange for money or drugs?			
Have you ever been sexually active with a person who was known or suspected to have HIV, hepatitis B or hepatitis C?			

FDA Risk Factors	Yes	No	Comments
Have you been exposed to body fluids, open wounds, non-intact skin or mucus membranes of any person known or suspected to have HIV, hepatitis B and/or C?			
Have you had an accidental needle stick within the past 12 months?			
Have you ever been or have you had a sexual partner who was incarcerated for 72 consecutive hours or longer?			
In the past 12 months, have you lived with or had contact with anyone known or suspected to have hepatitis?			
Have you acquired a tattoo or other skin piercing procedure within the preceding 12 months?			
Have you ever been diagnosed with hepatitis?			
Have you been vaccinated or had contact with anyone vaccinated for smallpox within the past 2 months?			
Have you ever been diagnosed with or suspected to have West Nile Virus?			
Have you ever been treated for or diagnosed with chlamydia, gonorrhea, herpes or syphilis?			
Have you or any of your blood relatives been diagnosed and/or have a history of transmissible spongiform encephalopathy such as Creutzfeldt-Jakob disease or variant disease? (Mad Cow Disease)			

FDA Risk Factors	Yes	No	Comments
Have you ever received a non-synthetic dura mater transplant or a pituitary-derived growth hormone?			
Do you have a history of changes in cognition, speech or gait?			
Have you ever received a blood transfusion?			
Have you visited or lived in the United Kingdom for three months or more between 1980-1996 including England, Scotland, Wales, Ireland, Isle of Man, Channel Islands, Gibralter or Falkland Islands?			
Were you a member of the US military, civilian military, employee or a dependent of a member of the military stationed in Belgium, the Netherlands, Germany, Spain, Portugal, Turkey, Italy or Greece between 1980-1996?			
From 1980 to present, have you spent time that adds up to 5 years or more in Europe?			
Were you born in or have you lived in any of the following Countries since 1977; Cameroon, Central Africa Republic, Chad, Congo, Equatorial, Guinea, Gabon, Niger or Nigeria?			
If yes, were you given a blood transfusion or any medical treatment with a product made from blood while you were there?			

FDA Risk Factors	Yes	No	Comments
Have you ever had sexual contact with anyone who was born or lived in Cameroon, Central Africa Republic, Chad, Congo, Equatorial, Guinea, Gabon, Niger or Nigeria since 1977?			
Have you or someone you know been diagnosed, treated or suspected of having sudden acute respiratory syndrome? (SARS)			
Have you, your sexual partner, and/or anyone you live with ever had a transplant or other medical procedure that involves being exposed to live cells, tissues or organs from an animal?			
Have you been exposed to blood, saliva or fluids from the person described in the proceeding question?			
Have you ever received a human organ, tissue transplant or human extract?			
Have you ever been excluded as a blood donor?			
Have you been diagnosed or suspected to have Chagas' disease?			
Have you been exposed to significant levels of radiation, toxic chemicals, or heavy metals (such as lead, mercury or gold) in your home or work environment?			
Have you received a bite from an animal suspected for rabies within the last six months?			

Consent

Under the penalty of perjury, I attest that all of the information I have provided in my donor application is true and complete to the best of my knowledge. I also have a good understanding of the commitment involved in the donation process.

I give An Eggceptional Match, LLC full authority to include my photographs on it's website, and to share my personal profile with prospective parents but without disclosing to them any of my identifying information. I hereby release An Eggceptional Match, LLC and Angela Bevill, and their agents, employees, successors and assigns, from any and all liability of any nature whatsoever as a result of such disclosures.

I understand that typing my name constitutes a legal signature confirming that I acknowledge and agree to the above Consent.

_____

Donor's Printed Name:

_____ _____

E-Signature: Date of Birth

Date: _____