

CHECK LIST FOR CONTRACT PREPARATION

Intended Parent 1:

- Male
- Female

Name: _____

Address: _____

Phone: _____

Email address: _____

County of Residence: _____

Country of Residence: _____

Date of Birth: _____ Age _____

Intended Parent 2:

- Male
- Female

Name: _____

Address: _____

Phone: _____

Email address: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Are IPs represented by an Attorney? _____yes _____ no

If yes, Name: _____

Address: _____

Phone: _____

Are the Intended Parents Married? _____yes _____ no

If yes, is the marriage recognized in the State of Ohio? _____yes _____ no

If no, are they engaged to married? _____yes _____ no

If yes, when? _____

Carrier:

Name: _____

Address: _____

Phone: _____

Email address: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Carrier's Spouse/Partner:

- Male
- Female

Name: _____

Address: _____

Phone: _____

Email address: _____

County of Residence: _____

Country of Residence: _____

Date of Birth _____ Age _____

Is Carrier represented by an Attorney? _____yes _____ no

If yes, Name: _____

Address: _____

Phone: _____

Is the Carrier Married? _____yes _____ no

If yes, is the marriage recognized in the State of Ohio? _____yes _____ no

If no, is the Carrier engaged to be married? _____yes _____ no

If yes, when? _____

Is the Carrier related to the Intended Parents? _____yes _____ no

If yes, how? _____

Does Carrier have any children of her own? _____ yes _____ no

If yes, how many children and their ages _____

Does Carrier’s Husband have any children of his own? _____ yes _____ no

If yes, how many children and their ages _____

Whose egg will be used: _____
Intended mother/carrier/anonymous egg donor/embryo donor

Whose sperm will be used: _____
Intended father/donor sperm/embryo donor

****If you are using donor eggs or donor sperm, please obtain a copy of the Donor Consent Form from the facility in which you are obtaining the eggs/sperm. Provide a copy to Attorney Hete as soon as possible.****

Are the IPs using a Fertility Clinic/Fertility Program? ___ Yes _____ no

If yes:

Name _____

Address _____

Phone _____

Name of Physician you worked with _____

Name of Embryologist (if not Physician) _____

Name of Nurse (if applicable) _____

When did you engage the services of the program? _____

Do you have a contract with the program _____ yes _____ no

If yes, please provide a copy of the contract to Attorney Hete.

Will the above named clinic/program be creating/have they created the embryos to be used for this surrogate pregnancy? _____ Yes _____ no

If yes, please provide the name of the Physician, Embryologist and any nurse who will assist in the creation of embryos, including egg retrieval, sperm retrieval and IVF procedures.

Name (Physician) _____

Name (Embryologist) _____

Name (Nurse) _____

Name (other professional) _____

If NO: please provide the information relevant to the clinic who will create the embryos or provide information regarding the origin of the embryos:

Name _____

Address _____

Phone _____

Name of Physician you worked with _____

Name of Embryologist (if not Physician) _____

If you are creating/using embryos for transfer:

How many embryos will be transferred _____

How many attempts will be made if any attempt fails _____

Are there already embryos available _____ yes _____ no

Date of sperm collection _____

Date of egg retrieval _____

If you plan to become pregnant through Artificial Insemination:

Home insemination _____ yes _____ no

Physician insemination _____ yes _____ no

be advised, Ohio law only recognizes inseminations performed by physicians

If you are using a Physician to perform the insemination:

Name of Physician: _____

Address _____

Phone _____

The child will be delivered at _____ hospital

Hospital

Name: _____

Address : _____

Phone: _____

County: _____

OBGYN

Name of Physician who will provide pre-natal care _____

Name of Group/Clinic Physician works with _____

Address _____

Phone _____

Will this physician do the delivery? _____ Yes _____ No

Amount of Base Compensation \$ _____

Paid at what rate _____

Amount paid for multiple pregnancy \$ _____

Amount paid for maternity clothing \$ _____

Amount paid for travel/meals \$ _____

Payment for bed rest? _____ Yes _____ no

Will IPs provide term life insurance during the contract? _____ Yes _____ no

If yes, in what amount \$ _____

Does the Carrier have health insurance that does NOT exclude surrogacy?

_____ Yes _____ no _____ don't know

Will IPs provide housekeeping? _____ Yes _____ no

Will the IPs pay for loss of reproductive organs? _____ Yes _____ no

Will the IPs pay for Carrier's attorney to review the contract? _____ Yes _____ no

Will the parties accept selective reduction? _____ Yes _____ no

The birth of the child will take place in _____ County, _____.
What county State

**FEE TO PURCHASE CONTRACT:
\$2,500**

Fees include negotiation, clearance letters, notarization, copies to all necessary parties, and all necessary paperwork for medical authorization to commence procedures. **Fees are for contract construction only and are not applied to any pre-birth or post-birth litigation.** Pre-birth and post-birth matters are engaged under a separate contract.

Please complete this form and return it
via FAX or EMAIL
to **Attorney Emily M. Hete**
330-666-1532 fax

Questions? Call 330-666-6400

Make Checks Payable to:
Emily M. Hete, Esq.

Mail Checks to:
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Akron, OH 44333