

Female Patient Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

**THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY\***



**DONOR EGG PROGRAM AGREEMENT  
DONOR**

**Description, Explanation and Informed Consent**

I realize that it will take a total commitment on my part to participate in the program. I understand and agree to the following:

1. To undergo any blood tests for hormone levels, infectious disease, and drug screening that are needed.
2. To undergo psychological screening as required.
3. To take all medications as instructed:
  - a. Daily injections of Lupron for 2-6 weeks.
  - b. Once or twice daily injections of gonadotropins to stimulate my ovaries to produce more than one egg.
  - c. One injection of human Chorionic gonadotropins (hCg) to help mature eggs and prepare them for egg retrieval.
  - d. The possible use of antibiotics taken by mouth to prevent infection.
  - e. Any other medications as instructed.
4. To keep all appointments for vaginal ultrasounds and laboratory tests in order to be closely monitored.
5. To abstain from intercourse or to use a non-hormonal form of contraception such as tubal ligation, condoms, or a diaphragm, if I do have intercourse during the cycle.
6. To notify the CHR staff if I engage in intercourse with a new partner.
7. To refrain from the use of all recreational drugs. To report any prescription or non-prescription drug use to CHR's egg donor coordinator.
8. To undergo oocyte aspiration which is performed by a needle being placed into my ovaries using transvaginal ultrasound guided techniques with intravenous sedation.
9. To donate all my retrieved oocytes (eggs) to a recipient who will be matched with me at the beginning of the cycle. On behalf of myself, my agents, my heirs, administrators, personal representatives, executor, or spouse. I RELINQUISH ANY CLAIM TO ALL OOCYTES (EGGS) AND/OR OFFSPRING THAT MAY RESULT FROM THE USE OF MY EGGS FOR INVITRO FERTILIZATION at the time of egg retrieval. I understand that I may be matched to more than one recipient in a given cycle.

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\*Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)

10. That my compensation for my expenses, inconveniences, risks, and discomfort as a result of participating in and completing the egg retrieval will be \$5,000.00 in the state of Illinois and \$7,000.00 in the state of New York. I also understand that once I have begun injectable medications I will be reimbursed \$1,000.00 in the event the cycle is cancelled, through no fault of my own before egg retrieval. I realize that if I fail to comply with any treatment or requirements jeopardizing the cycle and causing it to be cancelled, I will NOT receive any compensation due to the undue psychological, physical, and financial stress I have caused the recipient couple.
11. I understand that if I experience complications or require hospitalization as a result of my participation in this program that any expenses not covered by my own health insurance will be reimbursed with appropriate documentation.

"On behalf of myself, my agents, assigns, heirs, administrators, personal representatives, executors, and spouse, I release and forever discharge the A.R.T. Team from all damages or causes of action, either at law or in equity, which I may have or acquire or which may accrue to me or my spouse, agents, assigns, heirs, administrators, personal representatives or executors as a result of the donation or medical care related thereto."

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Patient Name—Print

**I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risk attendant to the donation of eggs and hereby signify my agreement to my spouse's participation in the procedure.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Social Security Number

**All of our questions regarding the Center for Human Reproduction Donor Egg Program Agreement—Donor have been answered. Each of us has read the consent and acknowledges receipt of a copy of this consent.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Female Patient

\_\_\_\_\_  
Female Name – Print

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Applicable)

\_\_\_\_\_  
Spouse Name – Print

**As one of the members of The Center for Human Reproduction, by my signature indicate that the foregoing consent was read, discussed and signed in my presence.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness (Female Patient)

\_\_\_\_\_  
Witness Name – Print

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Date

Signature of Witness (Spouse)

Witness Name – Print

**NOTE: If you or your partner are unable to have this consent witnessed by a staff member at CHR or FULLY UNDERSTAND THE CONSENT, please notify the CHR medical staff. We will provide you with further information and a witness. If you wish to sign the consent outside of CHR, please have the consent notarized.**

State of \_\_\_\_\_, County of \_\_\_\_\_ ss., I, the undersigned, a Notary Public in and for the said County in the

State aforesaid; DO HEREBY CERTIFY that \_\_\_\_\_  
(Female Patient / Spouse)

personally known to me as the same persons whose names are subscribed to the foregoing document appeared before me this day in persons, and acknowledged that he and she signed, sealed and delivered the said document as his and her free and voluntary act, for the use and purposes therein set forth.

Given under my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_,

Commission expires on: \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

(Notary Seal)