MEDICAL AUTHORIZATION

(No Coverage Given - Not Valid if Submitted Later Than 5 Days from Heartbeat Confirmation)

Gestational Surrogate (Patient): ____
(Please print gestational surrogate name)

***Date of Birth:** ________ / ________ / ________ **ID#** ______________________________
*Gestational Surrogate must be between the ages of 21 and 39

I am a board-certified physician in obstetrics and gynecology and/or specialist with qualifications in infertility medicine and reproductive endocrinology. I hereby further confirm that to date, the above-named proposed surrogate 'patient' has experienced normal health maternity without any adverse medical conditions and has no known or existing and/or prior medical conditions that may cause concern of any medical complications related to maternity and childbirth.

I have examined and currently care for the above proposed gestational surrogate /patient and find her to be in continued excellent physical condition and general health, except as noted below:

Adverse Findings:

____

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____

Gestational Surrogate Required Information:

Weight: ________ **BMI:** ________ **Glucose Level:** ________

Height: ________ **Blood Pressure:** ________

Date of Most Recent Pregnancy: ____/____/____ Named gestational surrogate heron confirms that their most recent pregnancy and all previous pregnancies were healthy, without any known medical complications and by vaginal birth. If not, please explain:

____

____

Please check the appropriate box:

[ ] I recommend the above-named patient to act as a gestational surrogate.
[ ] I decline to recommend the above-named patient to act as a gestational surrogate.

________________________________ ________________________________
Name of Examining Doctor (Please Print) Signature of Examining Doctor

________________________________ ____________________ ____/____/____
Name of Medical Facility Or Practice Telephone Number Date