The Operation Baby Foundation

Medical Infertility Diagnosis Form

FOR OFFICE USE ONLY

Important: Please complete this form and upload it to your online application.
For any questions, contact The Operation Baby Foundation at: **info@operationbaby.org**

PART I: APPLICANT INFORMATION

Primary Applicant:

- Full Name: _____
- Date of Birth (MM/DD/YY): _____
- Occupation: _____
- Home Address: _____
  City: _____ State: _____ Zip: _____
- Email: _____
- Phone Number: _____

Partner (if applicable):

- Full Name: _____
- Date of Birth (MM/DD/YY): _____
- Occupation: _____
- Home Address: (if different): _____
  City: _____ State: _____ Zip: _____
- Email: _____
- Phone Number: _____

PART II: ADOPTION PLAN DETAILS

1. Infertility Diagnosis:

- Has the applicant been diagnosed with medical infertility?
  ☐ Yes ☐ No
  If yes, please indicate the date of diagnosis: _____
- Diagnosis/Cause (if known): _____

2. Treatment History:

- How long have you been experiencing infertility? _____
- Have you pursued any prior fertility treatments? ☐ Yes ☐ No
  If yes, please provide details:
  - Types of treatments (e.g., IVF, IUI, medications): _____
  - Number of cycles: _____
  - Dates of treatments (MM/YY): From to
  - Outcomes (e.g., pregnancy, miscarriage, not pregnant): _____

PART III: PERSONAL BACKGROUND

Fertility Clinic or Physician:

- Name of Clinic/Physician: _____
- Address: _____
  City: _____ State: _____ Zip: _____
- Contact Number:_____
- Email: _____

Physician Certification:
I certify that the patient listed above has been diagnosed with infertility and has undergone the treatments described.

Physician Name (Print): _____

Physician Signature: _____ Date: _____

PART IV: FUTURE PLANS

1. Are additional fertility treatments planned?
☐ Yes ☐ No ☐ Unsure

If yes, please provide details about planned treatments:

PART V: SIGNATURE & CONSENT

I understand the contents of this form and agree to allow The Operation Baby Foundation to use the information provided for the purpose of determining grant recipients. I certify that the information provided is accurate to the best of my knowledge. I authorize Operation Baby to contact the listed adoption agency to verify the information disclosed in this document.

Applicant Signature: _____ Date: _____

Partner Signature: _____ Date: _____