



# SEEDS OF LIFE

## EGG DONOR APPLICATION

Donors Chil/dhood Photo

Donors Childhood Photo

Please fill the form completely and email to [info@seedsoflifeZA.co.za](mailto:info@seedsoflifeZA.co.za)

## Contact Information (This Will Be Kept Confidential)

Name:		
Surname:		
ID Number:		
Do You Have A Passport:		
Residential Address:		
Place Of Work:		
Position:		
Email:		
Work Phone:		
Home Phone:		
Cell Phone:		
Two Contact People That Know About Your Involvement with Egg Donation	Name	Cell No
In Which City Can You Donate (CPT/ DUR / JHB / PTA/ NS):		
Do You Stay More Than 100Km From Any of the Major Cities		

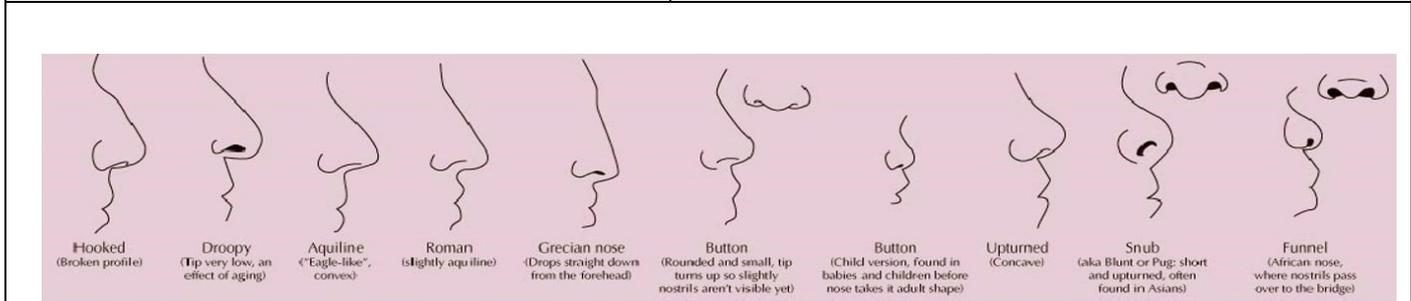
## Personal Information

Which City Do You Reside in:	
Race Group:	
Religion:	
Date of Birth:	
Nationality:	
Marital Status:	

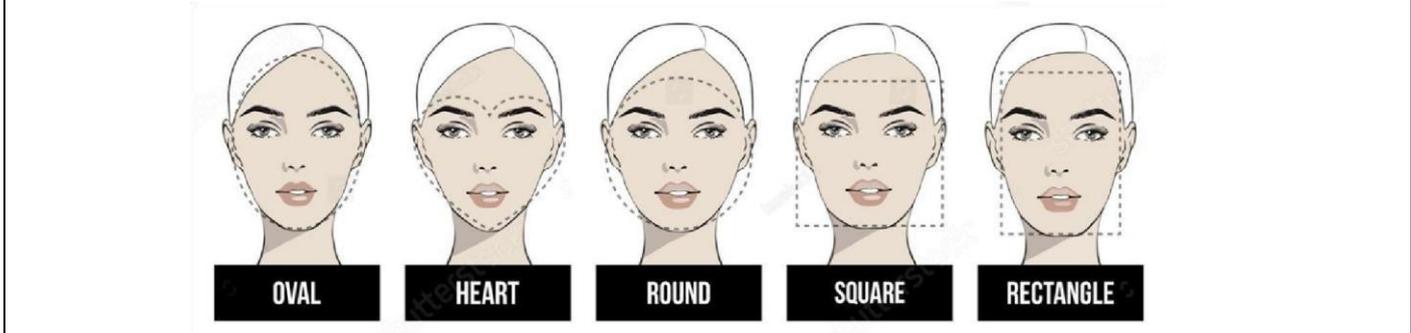
Are you Adopted:	
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## Physical Information

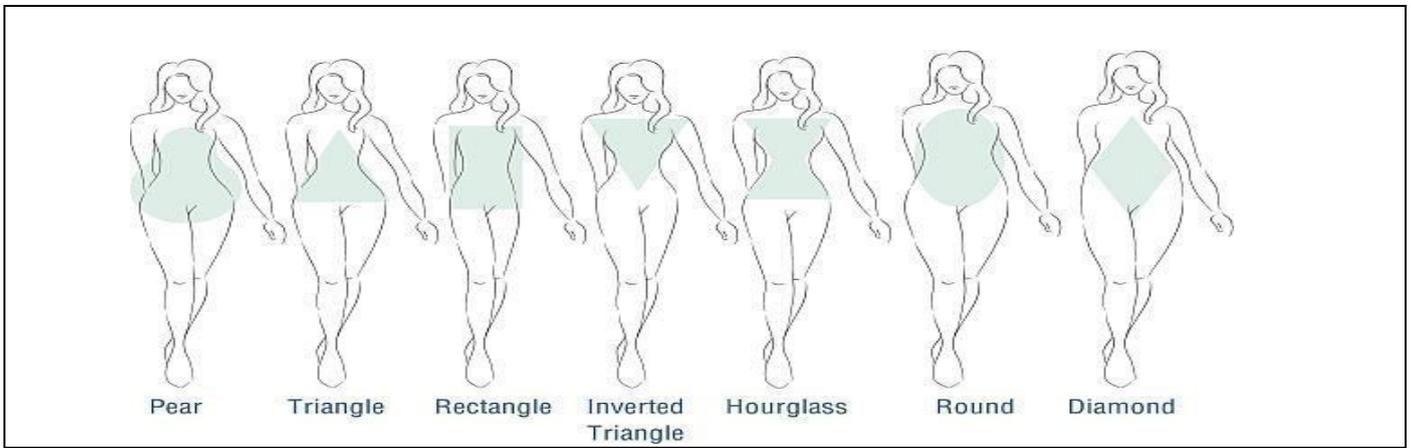
Height (meters):	
Weight (Kg):	
BMI:	
Eye Colour:	
Vision:	
Do you wear Corrective Lenses:	
Natural Hair Colour:	
Natural Hair Texture:	
Natural Hair Form:	
Hearing:	
Complexion:	
Nose Type: (Please Select)	



Face Shape: (Please Select)	
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Body Frame: (Please Select)	
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Dominate Facial Feature:	
Predominant Hand:	
Other Defining Traits?	
Which Famous Person Do You Look Most Like?	

Celeb Pic

### Ethnic Background

Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

### Academic And Professional Information

Highest Completed School Grade:	
Favourite Subject/s At School:	
Are You Currently Enrolled At An Educational	

Institution: eg. College/Technikon/University	
If Yes, What Area Of Study (Degree / Diploma)	
Are You Currently Employed:	
What Position Do You Hold In The Company:	
Description Of Position:	

### Personality

Why Do You Want To Become An Egg Donor:	
Describe Your Personality And Character:	
Skills And Abilities (eg: Singing /Acting)	
Hobbies:	
Favourite Book:	
Favourite Movie:	
Favourite Actor:	
Favourite Colour:	
Favourite Food:	
Dream Destination (To Visit Or Stay)	
If You Could Spend A Day With Anyone In The World, Who Would It Be And Why:	
Tell Us About Your Future Plans And Goals:	
What is Your Greatest Strength:	
What is Your Greatest Weakness:	
What is Your Dream Job:	
How Would You Sum Yourself Up In One Sentence:	
Please Write A Special Message For The Recipient:	

### Diet And Exercise

Do You Exercise / Play Sport?	
How Many Hours A Week ?	
Diet Description:	

### Medical Information

Blood Type:	
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General Health:				
Smoker:				
If Smoker, Number of Cigarettes Smoked Daily?				
Do You Consume Alcohol?				
What is Your Frequency Of Consumption ?				
Allergies (Please Specify):				
History Of Substance Abuse:				
Description Of Substance Abuse:				
Please list any prescription, non-prescription, or recreational drugs that you have used in the past five years, or currently use:	Name Of Medication	Start Date	End Date	Frequency
Have You Ever Had Surgery (Please Specify):				
Have You Ever Had Psychological / Psychiatric Care ?				

Fertility Informator	
Are You A Virgin?	
Do You Have A Regular Menstrual Cycle?	
How Long Is Your Menstrual Cycle?	
How Many Days Does Your Period Last?	
Do You Experience Painful Periods ?	
If Yes, Do You Use Medication Or A Hot Water Bottle?	
Have You Ever Been Told You Are Infertile?	
Present Form Of Birth Control:	
Have You Ever Been Pregnant?	
Have You Had A Miscarriage?	

Have You Even Had A Termination Of Pregnancy? (Medical/Elective)				
How Many Children Do You Have?				
Reproductive Illness?				
Is There History Of Family Twining?				
Have You Donated Before? (When and Where)				
Have You Or Any Of Your Sexual Partners Been Tested For	Yes / No	Me / Partner	Date Tested	Result
HIV (AIDS) virus				
Chlamydia				
Gonorrhoea				
Herpes				
Syphilis				
Hepatitis B or C				

### Family History

Do You Have Any Siblings? (Please Specify, eg: Brother/Sister)		
In What Year Were Your Siblings Born?		
Are There Any Know Any Genetic Conditions That Run In Your Family?	Condition	Family Member
Have You Even Been Tested For The Following Genetic Disease?	Yes / No	Date Tested
Tay-Sach's Disease		
Sickle Cell Disease		
Thalassemia		
Cystic Fibrosis		
From The List Below, Please Indicate Which Are Present In Your Biological Family	Yes / No	Family Member
Asthma		
Thyroid Problems		
Epilepsy		
Deformities (Cleft Lip/Palate)		
Glaucoma/Cataracts		
Blood Transfusion		
Diabetes:		

Cholesterol		
Haemophilia / Bleeding Disorder		
Allergies		
HIV / AIDS		
Eczema		
Mental Illness		
Anaemia		
High Blood Pressure		
Genetic Disease		
Cancer (Type And Age Of Onset)		
Heart Problems		
Kidney Disease		
Down's Syndrome		

Family Health			
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	Excellent	Fair	Poor
You			
Mother			
Father			
Sibling 1			
Sibling 2			
Sibling 3			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Donors Declaration	
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The Pictures That I Have Provided Are Of Me	
The Information That I Have Provided Is Correct	
I Agree To Participate In the Egg Donation Program	

I Confirm To Take All Medication That Will Be Provided To Me As Directed, and Make Myself Available To The Scheduled Appointments And Scans	
I Agree That I Have No Responsibilities Over Any Children Conceived Through My Donation	

## Consent to Process Personal Information

I, \_\_\_\_\_, with identification number

hereby provide my consent to Seeds of Life Donor Agency (the "Agency") to collect, process, store, and share my personal information in accordance with the Protection of Personal Information Act, 2013 (POPIA).

### Purpose of Processing:

I understand that my personal information is required for the following purposes:

- To assess my suitability as an egg donor.
- To facilitate the egg donation process.
- To comply with legal and regulatory requirements.
- For medical and health purposes related to the donation.
- For communication and administrative purposes related to the donation.

Types of Personal Information; I hereby consent to the processing of the following types of personal information:

- Full name, date of birth, identification number, and contact details.
- Medical history and health information. ● Genetic information.
- Photographs and other identifying information.
- Any other information necessary for the donation process.

### Collection and Use:

- I understand that my personal information will be collected directly from me, from medical practitioners, and from other relevant sources as necessary for the egg donation process.

### Sharing of Information:

I hereby consent to the sharing of my personal information with:

- Medical professionals and healthcare providers involved in the donation process.
- Legal and regulatory bodies as required by law.
- Recipients of the donation, under conditions of anonymity and confidentiality.
- Any other third parties as required for the fulfilment of the donation process, under strict confidentiality agreements.

### Storage and Security:

- The Agency will implement appropriate technical and organizational measures to ensure the security and confidentiality of my personal information, in accordance with POPIA.
- My information will be stored securely and will only be retained for as long as necessary for the purposes stated above or as required by law.

### Right to Withdraw Consent

- I understand that I have the right to withdraw my consent at any time by providing written notice to the Agency.

- However, I acknowledge that the withdrawal of consent may affect the continuation of the donation process.

Access and Correction

- I have the right to request access to my personal information and to request correction or deletion of any inaccurate, irrelevant, excessive, or outdated information by contacting the Agency.

Contact Information

- For any inquiries or to exercise my rights regarding my personal information, I can contact Seeds of life donor agency at [info@seedsoflifeza.co.za](mailto:info@seedsoflifeza.co.za) 0663262772.

**Declaration:**

I declare that I have read and understood the contents of this consent form and that I provide my consent voluntarily.

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**Donor Name**

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**Donor Signature**

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**Date**