EXHIBIT A

MPI # _____

REPRODUCTIVE ENDOCRINE ASSOCIATES OF CHARLOTTE, P.C.

Consent for Gestational Carrier

INFORMED CONSENT

I, _____,
(Print full name as on driver's license)

desire to participate in the Gestational Surrogacy Parenting Program as a gestational surrogate through REPRODUCTIVE ENDOCRINE ASSOCIATES OF CHARLOTTE, P.C. ("REACH"). I understand that there are a number of steps to this procedure, and that starting this process does not guarantee that we will complete the process, achieve pregnancy, or that a healthy child will be delivered.

A. Purpose of Treatment.

I, the Gestational Carrier, understand that I have agreed to carry and deliver a child for the sole purpose of allowing the Female Partner and Male Partner (hereinafter referred to collectively as "Parents") to experience parenthood to their biological child(ren). I understand that the child(ren) conceived by the procedure described herein will not have my genetic material or that of my husband, but that of the Parents only. I relinquish all claim to the embryos placed into my uterus and any pregnancy or offspring that might result from the procedure described herein. I agree that Female Partner and Male Partner may regard any offspring resulting from the procedure described herein as their own child(ren).

B. Procedure to be Followed.

I agree that the doctors will obtain one or more eggs from Female Partner and through the process known as in vitro fertilization, inseminate these eggs with sperm from Male Partner (or a donor – if specified). The resultant embryo(s) will be replaced into my uterus in an attempt to establish a pregnancy. I agree that the Embryo Transfer Procedure may take place at the time of the IVF treatment cycle, or embryos to be transferred to my uterus may have been previously cryopreserved by the Parents from a previous IVF treatment cycle. Once pregnant, I agree to carry the resulting child for the sole purpose of delivering one or more children for the Parents.

I agree to appropriate drug administration, monitoring of hormones and other medical tests for the timing of the embryo replacement. I agree to the replacement of the resulting

embryo(s) into my uterus. This transfer of the embryos will be made through my cervix via a small catheter. There is no guarantee that I will become pregnant or that I will carry any resulting child to term. Realizing the complexity and prolonged nature of this treatment, it is still my wish to proceed with this process.

C. Risks.

I understand that the following is a description of are some of the risks which may reasonably be expected from the procedure described herein:

(1) Hormone Treatment. The risks associated with taking hormones to recreate the menstrual cycle are probably much less common than the known risks of pregnancy. Women may experience none to all of the following symptoms: nausea, vomiting, slight weight gain or loss, breast tenderness and enlargement, occasional vaginal bleeding, changes in skin pigment on the upper lip, under the eyes, or on the forehead, yeast infections of the vagina, vaginal discharge and wetness, menstrual period cramping, headaches and fluid retention. Much less common side effects include appetite changes, nervousness and fatigue and changes in sex drive. More serious but rare side effects include hypertension (high blood pressure), gallbladder disease, blood clots developing in the legs, lungs, eyes, brain, heart or elsewhere, heart attacks and strokes. I have been advised that I am at more risk for developing heart problems and blood clots if I smoke, or if I have smoked in the past.

(2) Blood Drawing. Mild discomfort and the possibility of developing a painful bruise or nerve injury at the needle site may occur. A blood clot in the vein may occur.

(3) Embryo Transfer. Minimal discomfort, possible infection, or ectopic pregnancy (a pregnancy outside the uterus) may result. The use of a catheter or dilating instrument inserted into the uterus may cause uterine cramping and occasional vaginal bleeding. These procedures carry a small risk of uterine perforation.

(4) Ultrasound. This examination involves the use of a form of energy (sound waves) which at high energy levels may produce heat and tissue damage. At the extremely low energy levels utilized in diagnostic ultrasounds no adverse effects have been observed.

(5) Controversial Ethics. Certain aspects of the ethics of this treatment are controversial. Some members of the community, including family or friends may not approve of this treatment. This disapproval may damage interpersonal relationships.

(6) Multiple Pregnancies. Replacement of more than one embryo increases the chance of pregnancy and the chance of multiple pregnancy (twins, triplets, quadruplets, etc.). A procedure known as fetal reduction of pregnancy has been proposed for some women whose pregnancies involve three (3) or more fetuses. More information on this controversial procedure is available on an individual

basis. Multiple pregnancies carry higher than normal risks for the gestational carrier for hypertension and other disorders. These pregnancies may lead to emotional and financial strain for the family. Deaths of babies around the time of delivery and the number of babies born with long-term handicaps are several times more common in multiple births than in single births. Multiples are commonly born before they are fully mature. The following disorders are responsible for increased illness and death of infants: infection of the membranes sometimes due to premature rupture of the membranes, twin-to-twin transfusion syndrome, placental infarcts (portions of the placenta lose their blood supply), and premature separation of the placenta and compression of the cord. Also, higher numbers of birth defects occur in offspring of multiple-fetus pregnancies for reasons not fully understood.

(7) Unknown Complications. There may be other complications with have not been listed that my occur.

The major risk of the aforementioned procedure is that the treatment may not succeed. Should the process not succeed, I may feel frustration, anxiety, and depression, all of which may be severe.

I am fully aware that little information exists regarding the true incidence of the above risks, both as they relate to hormone replacement and pregnancy. My doctors have informed me that the likelihood of the above complications may be increased as a result of this procedure. I accept these risks.

D. Reasons for Possible Failure.

The following is a partial list of the reasons that this procedure may fail, if frozen:

(1) The embryo(s) may not survive the prefreeze culture, freeze or thaw.

(2) The embryo(s) once thawed may not develop properly.

(3) The egg(s) may not develop normally.

(4) Loss or damage of the embryo(s) may occur during the procedure.

(5) Implantation of the embryo(s) may not occur during the procedure.

(6) There may be other reasons.

E. No Monetary Consideration Given By REACH.

My consent to this treatment is purely voluntary. No financial inducements have been offered by REACH or any of its employees, physicians, or agents.

F. **Confidentiality**.

Any information obtained during this procedure and identified with me will remain confidential and will be disclosed only with my permission. Any publication resulting from this procedure will not identify me individually. Representatives of The Food and Drug Administration (FDA), The Center For Disease Control (CDC), The Department of Health and Environmental Control of North Carolina, and The Society of Assisted Reproduction Technologies (SART) may inspect REACH's records.

G. **Execution of Consent**.

By signing this form below I expressly indicate and certify the following:

(1) That I have read and understand each and every provision herein;

(2) That I have been given the opportunity to review this document with any and all third parties of my choosing;

(3) That I have been given an opportunity to ask any and all questions;

(4) That for each question I have asked, I have received a satisfactory answer;

(5) That I know that I may ask additional questions at any time in the future;

(6) That I may discontinue this program at any time in the future; and

(7) That I am over the age of twenty-one (21).

_____ _____

Gestational Surrogate's Signature Date

_____ _____

REACH representative verifying completion of consent Date

_____ _____

Witness – if signed outside of REACH Date