The Institute for Reproductive Medicine and Science
at Saint Barnabas
94 Old Short Hills Road, East Wing Suite 403
Livingston, NJ 07039

DONOR SCREENING QUESTIONNAIRE

Name: _____ Date: _____

The United States Food and Drug Administration has issued its final rule on eligibility for human cells, tissues, and cellular and tissue-based products. Effective in 2005, donors of reproductive tissue are subject to the same screening and testing as donors of bone-marrow, blood, kidneys, and other organs. The regulations require that IRMS perform an eligibility determination for cell and tissue donors, based on testing and screening for relevant communicable diseases. This is for the protection of possible recipients of the tissue, as well as those people who may handle or come in contact with the tissue.

Please read and answer the following questions carefully. We recognize that some of the questions are of a sensitive nature, and thank you for providing the most accurate information.

		YES	NO
1.	Are you in generally good health?		
2.	In the past 12 months have you or your partner had a blood transfusion?		
3.	In the past 5 years have you had sexual contact with a man who has had sexual contact, either anal or oral with another man?		
4.	Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection?		
5.	Do you have a clotting disorder for which you have received human-derived clotting factor concentration?		
6.	Have you had sex for drugs or money in the past 5 years?		
7.	Have you had sex in the past 12 months with anyone who would answer yes to the above 3 questions?		
8.	In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?		
9.	In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?		
10.	In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin, or mucous membrane?		
11.	In the past 12 months, have you been in close contact (I.e. sharing kitchen and bathroom) with a person having active viral hepatitis?		
12.	In the past 12 months, have you had tattooing, ear or body piercing, acupuncture, or electrolysis? Explain below		
	▪ Tattoos (when and where)		
	▪ Acupuncture/electrolysis (when and where)		
	▪ Ear, skin or body piercing (when and where)		
13.	In the past 12 months, have you had an accidental needle stick, sharp instrument injury, contact w/human blood serum or plasma in the eye, mucus membranes (lips, interior of nose) or sores?		
14.	After age of 11, have you ever had viral hepatitis? What type? Please explain:		
15.	Have you yourself received or had intimate contact (i.e. exchanged body fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?		

		YES	NO
16.	Have you had a recent smallpox vaccination or had close contact with the vaccination site of anyone else?		
17.	In the past 12 months have you had any shots or vaccinations? *If yes: What_____? When_____?*		
18.	Have you had a headache and fever within the last 7 days? *If yes: When_____? For how long_____?*		
19.	Have you ever received growth hormone made from human pituitary glands?		
20.	Have you ever been refused as a blood donor? If yes, please explain:		
21.	Have you ever received a dura mater (brain covering) graft?		
22.	Have you or any of your relatives ever had a Creutzfeldt-Jakob disease?		
23.	In the past 12 months, have you had a positive syphilis test?		
24.	In the past 12 months, have you had or been treated for syphilis or gonorrhea?		
25.	In the past 12 months, have you been in jail for more than 72 hours in a row?		
26.	From 1980 through 1996, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? *If yes, proceed to #26a; otherwise, go to #27.*		
26a.	Did you spend a total time of 6 mos or more associated with a military base in any of the following countries: Belgium, The Netherlands, Germany, Spain, Portugal, Turkey, Italy, or Greece?		
27.	In the past 3 years have you been outside the United States or Canada? *If yes: Where_____? When _____? How long_____?*		
28.	Since 1980, have you ever lived in or traveled to Europe? *If yes, proceed to #28a; otherwise skip to #29.*		
28a.	▪ Between 1980 and 1996 did you spend time that adds up to more than 3 mos or more in the UK?		
29.	▪ Since 1980 have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes in the UK?		
	▪ Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the UK between 1980 and 1996)?		
	▪ Have you been in a place affected by SARS or with an affected person with in the past 14 days?		
30.	Have you been treated for SARS in the last 28 days?		
31.	Were you born, lived in, or traveled to any African country, such as Cameroon, Central Africa, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria since 1977? *If yes, proceed to #31a; otherwise, go to #32.*		
31a.	When you traveled to _____, did you receive a blood transfusion or any other medical treatment with a product made from blood?		
32.	Have you had sexual contact with anyone who was born in or lived in any African country, such as Cameroon, Central Africa, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria since 1977?		
33.	Have you ever undergone a xenotransplantation (transplantation, implantation, or infusion of live cells, tissues, or organs from a non-human animal source) procedure or had intimate contact with a xenotransplantation recipient? *If yes: When_____?*		

Your complete honesty in answering all of the questions is very important for the safety of those who will receive donation. All of the information you provide will be confidential.

Printed Name: _____

Signature: _____ Date: _____

IRMS
REPRODUCTIVE MEDICINE
AT SAINT BARNABAS
LEADERS IN SCIENCE, PARTNERS IN CARE

OVUM DONOR PERSONAL HISTORY

Instructions

This document will be completed entirely by you and will provide a personal history of yourself that will be given to the ovum recipients. The recipients may some day give this document to any children that may result from your donated egg(s). While not every couple will choose to disclose this information to the child(ren), all parents want to be able to provide accurate medical information. If children are told that they are born through your donation, the information contained within this document may be very important to them for medical and psychological reasons. It is for these reasons that we ask you to answer each question as carefully and thoroughly as you are able.

All information requested is voluntary and will remain anonymous. Any identifying information such as name, social security number, and address will be omitted from the packet given to the recipients. A copy of this history form will be given to the recipients, but will exclude identifying information and the supplementary questionnaire.

Donating your eggs is a caring and generous act, given in spite of some risk and discomfort. Those couples who receive eggs feel deep gratitude and respect for the gift you give so willingly. Naturally, most recipients and their children want to know as much as possible about the medical history of the woman who made their family possible. Thank you for letting them know you a little better.

The Institute for Reproductive Medicine and Science at Saint Barnabas, P.A.

I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed:_____

INTERNAL USE

DATE: _____

CALLED: _____

CONSULTATION: _____

LETTER: _____

Donor History Form

Date: _____

Name: _____ Social Security #: _____

Address: _____ Insurance Co.: _____

_____ Insurance #: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Best Time to call: _____ Cell Phone: ( ) _____

E-mail: _____ Pager: ( ) _____

Please designate which numbers are confidential

How did you hear about this program?: ☐ Friend ☐ Printed Material ☐Internet Website:_____

PHYSICAL CHARACTERISTICS

Date of Birth:_____

Height: _____ Weight: at 21? _____ Current Wt.: _____

Eye Color: _____ Blood Type: _____

Body Frame: _____ small _____ medium _____ large

Natural Hair Color: _____

Hair (check all that apply)

____ curly/wavy (naturally) ____curly/wavy (processed)
____ straight (naturally) ____ straight (processed)
____ average texture ____ thin texture
____ premature graying (at what age _____)

Skin color ____ fair ____ medium ____ olive ____ lt. brown ____ dk. Brown
____ ebony ____freckled ____ rosy birthmarks _____

PERSONAL CHARACTERISTICS

Race/Ethnic Origin:

Mother _____ Father _____

Right Handed _____ Left-Handed _____ Ambidextrous _____

Marital Status: ____single ____married ____separated ____divorced ___widowed

Duration of relationship with partner: _____

Education:

_____ completed grade school
_____ completed high school (GPA _____)
_____ currently in college, pursuing degree in _____ (GPA_____)
_____ completed college, degree in _____ (GPA_____)
_____ currently pursuing advanced degree in _____
_____ advanced degree in _____

Testing Scores: SAT: _____ GRE: _____ MAT: _____ LSAT: _____ MCAT: _____

PERSONAL HEALTH HISTORY

VISION (without corrective lenses):

_____ Poor _____ Fair _____ Good _____ Excellent

Do you wear corrective lenses? _____ Yes _____ No

For what problem(s)? _____ Nearsighted _____ Farsighted

_____ Other (explain) _____

Age first wore glasses _____

PERSONAL HEALTH HISTORY, *CONTINUED*

HEARING (without corrective aids):
_____ Poor _____ Fair _____ Good _____ Excellent

Do you wear corrective aids? _____ Yes _____ No

For what problem(s)? _____

TEETH: _____ Poor _____Fair _____Good _____Excellent

Any abnormalities? _____ Orthodontic Work _____ At what age _____

Do you smoke cigarettes? _____ Yes _____ No

If Yes, how many packs per day? _____ #years _____

DIET: _____ Vegetarian _____ Non-Vegetarian

Diet (nutrition): _____ Poor _____ Average _____Good

Describe your likes & dislikes _____

ALLERGIES: _____ Yes _____ No

If yes, are they to: _____ Food(s) _____ Medication(s)
_____ Environmental _____ Other

For each allergy, describe specific substance and reaction(s) and age first noticed & treatment (if any):

Substance Age Reaction(s) Treatment

_____
_____
_____

List any allergies you have outgrown: _____
_____

Have you had any surgery (ies):

List any surgery(ies) you have had & dates of surgery

1._____
2._____
3._____
4._____

Have you had any hospitalization(s) not mentioned above: _____

_____
_____

Have you had a blood transfusion?_____

How long ago? _____

Have you had major radiation or X-Ray exposure? _____ Yes _____ No

If Yes, explain: _____

_____

PERSONAL HEALTH HISTORY, *CONTINUED*

Number of sex partners within the last 6 months: _____
If applicable, my sex partner has had other sex partners in the last 6 months: _____ Yes _____ No

_____
Signature

Method of contraception used: _____ How Long _____

Have you or any of your sexual partners had:

	Self	Partner	When	How Often
NSU (non-specific urethritis)				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Hepatitis				
Use of IV (intravenous) drugs				
Other sexually transmitted diseases				

REPRODUCTIVE HISTORY

Age at first period: _____ Days each cycle _____ Are periods regular/irregular _____
Any treatment needed for menstrual problems? _____ Birth Control Pills _____ Provera _____
Did you ever have trouble conceiving? Yes _____ No _____

List #of pregnancies & outcome:

Year	C-Section/Vaginal Delivery Healthy Baby	Miscarriage	Ectopic	Termination
1.				
2.				
3.				
4.				

Any complications: _____

PERSONAL HEALTH: WORK HISTORY / EXPOSURE

List jobs held in the past five years and exposure as noted.

Job Title	Dates of Employment		Exposure to chemicals, drugs, fumes, pesticides, asbestos, lead, gases (describe)
	Year Began	Year Ended	

PERSONAL FAMILY HISTORY

How many blood siblings are in your immediate family (including yourself)? _____
_____# of males _____# of females

Please describe your family members by the following characteristics:

******The following abbreviations in the table are:*
MGM = Maternal Grandmother MGF = Maternal Grandfather
PGM = Paternal Grandmother PGF = Paternal Grandfather

RELATION	EYE COLOR	HAIR COLOR	HEIGHT/ WEIGHT	COMPLEX ION	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Mother							
Father							
MGM*							
MGF*							
PGM*							
PGF*							
Brothers	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Sisters	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.

Are you adopted? _____ Yes _____ No

Have twins or multiple births occurred in your family? _____ Yes _____ No

Are there any known genetic diseases or conditions that run in your family? _____ Yes _____ No

If yes, please identify: _____

Have you ever been tested as a carrier of:

Tay-Sach's disease (if Jewish ancestry)	_____ carrier	_____ non carrier	_____ unknown
Sickle cell disease (if Afro American)	_____ carrier	_____ non carrier	_____ unkownn
Cystic Fibrosis (if Caucasian):	_____ carrier	_____ non carrier	_____ unknown
Thalassemia (if Italian-Greek)	_____ carrier	_____ non carrier	_____ unknown
Other genetic disease:			
Specify:_____	_____ carrier	_____ non carrier	_____ unknown

Carefully review the following list of medical problems and identify any which are present in the listed family members.

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
HEART							
Stroke							
Heart attach							
Heart disease							
1. from birth							
2. other							
Hardening of the arteries							
High blood pressure							
High cholesterol level							
BLOOD							
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding disorder							
Leukemia							
HIV virus							
Lymphoma							
Other blood disorder							
RESPIRATORY							
Hayfever/ environmental allergy							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Other lung disease							
GASTRO-INTESTINAL							
Ulcer of stomach or duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Cirrhosis							
Other liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
GASTROINTESTINAL							
Developmental disorders of the stomach and intestine							
Pyloric stenosis							
Rectal disorder							
Any other cancer/problem of digestive system							
METABOLIC/ENDOCRINE							
Diabetes mellitus							
Hypoglycemia							
Thyroid cancer							
Thyroid disease							
Goiter							
Adrenal dysfunction or disorder							
Hyperactivity							
URINARY							
Kidney disease							
Other disease of urinary tract (urethra, bladder, ureter)							
GENITAL/REPRODUCTIVE							
Undescended testicle							
Hermaphroditism/ ambiguous genitals							
Hypospadias							
Prostate cancer							
Testicular cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix, ovaries or uterus							
REPRODUCTIVE OUTCOMES							
2 or more miscarriages							
Stillborn							
Death of a newborn infant							
Neonatal jaundice							
NEUROLOGICAL							
Migraines							
Mental retardation							
Down's Syndrome							
Senility before age 50							
Multiple Sclerosis							
Cerebral Palsy							
Epilepsy / seizures							
Hydrocephalus							
Spina bifida / neural tube defect							
Hungtington's disease							
Gaucher's disease							
Wilson's disease							
Parkinson's disease							
Paraplegia							
Tourrette's Syndrome							
Scoliosis							
Other diseases of nervous system							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
MENTAL HEALTH							
Schizophrenia							
Manic depressive or bipolar disorder							
Other mental health disorder requiring hospitalization							
MUSCLE / BONE / JOINTS							
Muscular dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus							
Osteoporosis							
Dwarfism							
Arthritis							
Gout							
Myasthenia Gravis							
SIGHT/ SOUND/ SMELL							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Deviated septum							
Any other sight / sound /smell disorder							
SKIN							
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Neurofibromatosis							
Other disorders of the skin							
CONGENITAL ANOMALIES							
Cleft lip/palate							
Congenital hip problems							
Club feet							
Other							
THERMOSOMAL/ABNORMALITIES							
Turner Syndrome							
Kleinfelter Syndrome							
CONGENITAL ANOMALIES							
Cri du chat Syndrome							
Trisomy 18							
Trisomy 13							
Fragile X Syndrome							
Other							
OTHER							
Alcoholism							
Drug abuse, misuse or addiction							
Breast cancer/lumps/cysts							
Any other cancer not mentioned							
Any other condition not mentioned							

Explain: _____

What are the three most important characteristics to you that the recipient parents possess (e.g., religion, personality, appearance)?: _____

What do you hope to achieve by volunteering in the egg donor program (e.g., emotionally, financially)?: _____

What message would you like passed on to the recipient of your eggs/ their offspring?: _____

What helped you decide to become an egg donor?: _____

PLEASE ATTACH A RECENT CLEAR, COLOR PHOTOGRAPH OF YOURSELF
(For internal use only)

1. How would you describe yourself. Please include a description of your personality & temperament:

2. Describe your philosophy of life:

YOUR FAMILY:

Describe the following:

	EDUCATION	OCCUPATION	INTELLECTUAL ACADEMIC ACHIEVEMENTS	ARTISTIC ACHIEVEMENTS
Mother				
Father				
SIBLINGS Sisters 1. 2. 3. 4. 5.				
Brothers 1. 2. 3. 4. 5.				

YOUR CHILDREN:

Describe the following:

	PERSONALITY	ARTISTIC ABILITY	INTELLIGENCE	DISTINGUISHING CHARACTERSITICS
1.				
2.				
3.				
4.				

YOUR CHILDHOOD:
Describe yourself as a child (e.g., personality, health, happiness, etc.).

What was it like growing up in your family?

What religion did you belong to as a child?

What is your earliest memory as a child?

What problems did you have as a child (e.g., health, allergies, learning, social, etc.)?

WHEN I WAS A CHILD:
My favorite thing to do was: _____

At home I was expected to: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

YOUR TEENAGE YEARS:
Describe yourself as a teenager:

Describe your achievements:

Did you do poorly in anything?

Did you have any problems as a teenager (e.g., health, acne, social, educational, etc.)?

WHEN I WAS A TEENAGER:

My favorite subject(s) was: _____

My worst subject(s) was: _____

The activities I was involved in were: _____

The most important influence on me was: _____

In comparison to others I was: _____

I liked to go: _____

I traveled to: _____

I was talented as: _____

My ambition was to: _____

ADULTHOOD EDUCATION:

Years completed: _____
Colleges attended: _____
Major subject(s) studied: _____
Degrees earned or pursuing now: _____

RELIGION:

Are you an Athiest_____ Agnostic_____
How religious are you now? Very _____ Moderately_____
Occasionally attend_____ Not at all_____
Religion born into:_____ Religion practived: _____

ACTIVITIES:

How athletic are you?
Very Athletic_____ Average_____ Not Athletic_____
Do you exercise: Regularly_____ Occasionally_____ Rarely_____

What types of exercise or physical activities do you enjoy?

_____
_____

Do you have musical ability?

_____

What other skills or talents do you have (e.g., painting, writing, reading, ability at games, crossword puzzles, handicraft, etc.)? Please describe in detail.

_____
_____
_____

Describe any special interests you have (e.g., Girl Scout leader, fund raiser, pet owner, etc.).

_____
_____
_____

What physical, artistic, intellectual or social abilities do you feel best about?

_____
_____
_____

What have been your achievements as an adult?

_____
_____
_____

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94 Old Short Hills Road, East Wing Suite 403
Livingston, NJ 07039

SUPPLEMENTARY QUESTIONNAIRE

(*Not to be given to recipients)*

I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed: _____

PSYCHIATRIC AND COUNSELING HISTORY

1. Have you ever been hospitalized for substance abuse, depression, or any other psychological problem?

☐ No ☐ Yes (*If yes, please list dates and diagnosis)*:

Dates	Diagnosis/Reason

2. Have you ever been in counseling or psychotherapy?

☐ No ☐ Yes (*If yes, please list dates and diagnosis or reason)*:

Dates	Diagnosis/Reason

3. Have you ever had psychotropic medications (e.g. antidepressants, anxiolitics/anti-anxiety, antipsychotic, etc) by physician?

☐ No ☐ Yes (*Please give dates)*:

_____

4. Please list year and location of any body tattoos or piercings:

_____

PERSONAL HISTORY AND OPINIONS

5. Have you ever been arrested or convicted of any crime (other than minor traffic offenses):
☐ No ☐ Yes

6. Have you ever had children removed from your custody:
☐ No ☐ Yes *(Explain:* _____*)*

7. Are you currently involved in any lawsuits? ☐ No ☐ Yes

(If yes, please explain): _____

_____

_____

_____

_____

_____

_____

8. Do you or have you used any of the following:?
☐ No ☐ Yes (*If yes, please list dates and diagnosis or reason)*:

Substance	**Years or Dates**	**Frequency**
Alcohol		
Marijuana		
Cocaine		
Tobacco		
Caffeine		
Prescription Drugs		
Other		

9. Do you presently have any health problems? (*If yes, please describe):*

10. What do you think is the biggest stress in your life at present?

11. Describe the couple for who you would like to donate?

12. What do you anticipate your feelings and reactions will be to becoming an egg donor? What difficulties do you anticipate?

13. Have you had any personal experience with a traumatic event?

Event	Yes or No
Serious Accident	
Rape or sexual assault	
Incest, sexual or physical abuse	
Victim of any crime	
Other	

14. Have you been a donor before? If yes, indicate what type (*e.g. ovum, blood, bone marrow, etc.*)

_____

At this time the policy of this program is total anonymity. Should the disclosure policy change, would you like to know if pregnancy occurred?

☐ No ☐ Yes ☐ Uncertain _____

At present participants in this program are strictly anonymous. We would like your opinion on the following questions:

Would you be willing to: (check all that apply)

_____ Participate in annual follow-up for medical update and to explore reactions to ovum donation
_____ Speak by telephone with the recipients but not meet in person
_____ Share non-identifying letters
_____ Share a current picture of yourself
_____ Meet in person with the recipients
_____Exchange identifying information

Would you like to meet any children who may result from your egg donation once they reach 18 years of age?

Please check all that apply:

_____ Would definitely not like to meet
_____ Would like to meet the child(ren)
_____ Would like to share picture with child(ren)
_____ Would not object if child(ren) wished to meet but would not seek a meeting

Would you consider donating your eggs on more than one occasion:

☐ No ☐ Yes (*If yes, how many times do you anticipate donating your eggs)*: _____

Would you consider updating your records with any pertinent medical information that might impact the offspring from your donation?

☐ No ☐ Yes

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,