The Modern Miracle Foundation
hello@modernmiraclefoundation.com

Medical Evaluation

I, _____(*full name of physician*), treating physician at _____ (*name of fertility clinic*) support the grant application by _____ (*full name of applicant*) to The Modern Miracle Foundation. I certify that the information below is to the best of my knowledge and correct as of the date of the application on _____/_____/_____ (MM/DD/YYYY).

Physician Information
Full Name: _____
Title: _____
Affiliated Clinic: _____
License #:_____
Email:_____
(we will contact this email to confirm submission)

_____

Physician Signature

_____

Date

Medical Evaluation

1. Indication for Treatment:

   - ☐ Primary Infertility
   - ☐ Secondary Infertility
   - ☐ RPL
   - ☐ Single/LGBT2SQ+ Family Building
   - ☐ Other Indication

2. How many living children do they have? _____
3. Number of miscarriages to date: _____
4. Age of Applicant: _____
5. Please provide your diagnosis:

   - ☐ Ovarian
   - ☐ Tubal / Anatomic
   - ☐ Endometriosis
   - ☐ Male
   - ☐ Unexplained
   - ☐ Other (please explain below)

   _____

   _____

6. Number of IVF cycles performed to date ____ and number of failed transfers _____
7. Based on the information currently known and barring unforeseen circumstances, the Applicant and Co-Applicant (if applicable) has a probability of conception through IVF of _____% **(CLBR per cycle start rate).**

FOR OFFICE USE ONLY

Applicant ID: _____

Patient Story:

_____
_____
_____
_____
_____

MMF Advisor Comments: _____

MMF Advisor Signature:_____