FERTILITY
FOUNDATION OF TEXAS

3801 N. Capital of Texas Highway
Suite E-240, PMB #131
Austin, Texas 78746
www.FertilityFoundationofTexas.org
Email: info@fertilityfoundationoftexas.org

GRANT APPLICATION: TREATING PHYSICIAN FORM

I, _____, hereby confirm that I am the treating physician for_____ (patient's name) infertility care.

I am submitting this form to the Fertility Foundation of Texas per her/their request to establish that they have been evaluated by me and received a diagnosis and treatment plan. This patient's infertility diagnosis is: _____

_____

_____

The overall treatment plan I am recommending requires:

_____

_____

_____

_____

Please check all that apply:

- ☐ Donor egg and/or sperm recommended: _____
- ☐ Genetic screening recommended: _____

Has applicant undergone IVF in the past: ☐ Yes ☐ No

Signature: _____ Date: _____

Printed Name: _____