

Infertility Support Group Registration

NAME: _____ **D.O.B.:** _____ **AGE:** _____

ADDRESS: _____
Street Apt. City State Zip

HOME PHONE#: _____ **WORK #:** _____ **CELL #** _____

E-MAIL (please print clearly): _____

EDUCATION: _____

Brief Infertility History: _____

Are you currently in active treatment? (If yes please describe) _____

What do you hope to get out of attending the group?

Please explain briefly: _____

This group is offered as a professional service by Liz O'Donnell, PhD (LPCC). Although absolute confidentiality cannot be guaranteed in a group of this nature, it is understood that infertility is an intimate struggle and every effort is made to treat all disclosures with integrity. Your signature on this document confirms that you understand and respect this request as a participant. There is a \$20.00 fee per person for each meeting

Signature

Date