

Providing the following information will allow Department staff to contact you should additional information be needed. It is our policy to keep your name and any identifying information confidential. In order to address your concern, it may be necessary to share the nature of your complaint with the Gestational Surrogacy Program or individual you are complaining about.

1. First Name:
2. Last Name:
3. Address:
4. Phone:
5. Email Address:
6. Do you wish to remain anonymous to the Gestational Surrogacy Program you are complaining about?
(If you check yes, your name will not be shared with the Gestational Surrogacy Program; however, you must submit your identifying information to the NYS Department of Health)
Yes
No
7. Date of Occurrence:
8. Time of Occurrence:
9. Name of Gestational Surrogacy Program or individual(s) you are complaining about:
10. Address:
11. What is your relationship to the Gestational Surrogacy Program?
Please check: Surrogate
 Intended Parent
 Other (describe):
12. Have you filed a complaint or otherwise attempted to resolve your issue with the Gestational Surrogacy Program you are complaining about?
Yes (describe)
No
13. Provide a detailed description of the complaint below. [Please limit your description to 1500 words and attach to your email any material that substantiates your claim.]

