PATIENT INFORMATION

(PLEASE PRINT)

_____ _____

NAME *CITY AND STATE OF RESIDENCE*

PATIENT WARNING

NEVER give consent for an abortion until after the doctor who will be performing it has filled out and signed the PHYSICIAN DISCLOSURES section of this document. DO NOT allow anyone to destroy this document or take it away from you.

PHYSICIAN DISCLOSURES

The following information is to be completed by the physician who will be performing the abortion procedure on the patient named in this document (PLEASE PRINT).

_____

PHYSICIAN'S NAME

_____

NAME OF FACILITY WHERE ABORTION PERFORMED

_____

STREET ADDRESS WHERE THIS FACILITY IS LOCATED

_____

CITY AND STATE WHERE THIS FACILITY IS LOCATED

_____

PHYSICIAN'S MALPRACTICE INSURANCE COMPANY

_____

MALPRACTICE INSURANCE POLICY NUMBER

_____

NAME OF EMERGENCY CARE FACILITY WHERE PATIENT WILL BE SENT IF SHE IS INJURED AS A RESULT OF THIS PROCEDURE

AS THE PHYSICIAN NAMED HEREIN, I AFFIRM THE FOLLOWING STATEMENTS TO BE TRUE:

- I am a physician who is currently licensed to practice medicine in this state.
- My license to practice medicine has never been suspended or revoked in this or any other state.
- I have a current medical malpractice insurance policy with sufficient limits to compensate this patient should she be injured or killed while in my care.
- I have never had any claims or judgements against me for medical malpractice, personal injury, or wrongful death.

I further state that, **(a)** if this patient is injured while in my care, she will be immediately transferred by ambulance to the nearest emergency care facility; **(b)** if any abortion procedure that I perform on this patient fails or is incomplete, I will perform – at no additional cost to her or any third party – any and all subsequent medical procedures necessary to complete the abortion; and **(c)** if this abortion is to be done by chemical means (Medical Abortion), I will strictly adhere to all of the drug manufacturer's protocol including, but not limited to, dosage amounts, gestational age limitations, stipulations regarding oral or vaginal administration, sonogram use, and recommended follow-up procedures.

X_____ _____

PHYSICIAN'S SIGNATURE *DATE*