

Physician's Information

The following must be filled out and signed by the physician who will perform your abortion.

Name

Name of Facility Where Procedure Will Be Performed

City and State Where Facility Is Located

Name of Malpractice Insurance Company

City and State Where Insurance Company Is Located

Policy Number

Policy Limit and Date of Expiration

Name and Location of Nearest Trauma Center or Emergency Hospital

I certify that (1) all the information given above is true and accurate, (2) I am a physician licensed to practice medicine in this state, (3) my license to practice medicine has never been suspended or revoked in this or any other state, (4) I have a current and fully paid medical malpractice insurance policy with the company named above, (5) I have no claims or judgments against me for medical malpractice, personal injury or wrongful death, and (6) if you the patient are injured as a result of your abortion you will be immediately transferred by ambulance to the emergency facility named above.

Physician's Signature and Date