NCDHHS PHYSICIAN PROVIDER DECLARATION FORM FOR MEDICAL AND SURGICAL ABORTIONS

Patient Name: ____ **Date of Birth:** ________________

Physician Provider Declaration: By signing this form, I certify that I have explained the method of abortion to be used and that all information required by law was communicated to the patient and, if applicable, to the authorized guardian, prior to the procedure by a physician or qualified professional. I have answered all the patient's questions about the abortion procedure.

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PHYSICIAN PROVIDER'S NAME (PRINTED) PHYSICIAN PROVIDER'S SIGNATURE

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DATE