

- Physician's Name: \_\_\_\_\_
  
- Name of facility where procedure will be performed:  
\_\_\_\_\_
  
- City and state where facility is located:  
\_\_\_\_\_
  
- Name of malpractice insurance company:  
\_\_\_\_\_
  
- State where insurance company is located: \_\_\_\_\_
  - Policy number: \_\_\_\_\_
  - Policy limit: \_\_\_\_\_
  - Expiration date: \_\_\_\_\_
  
- Name of nearest trauma center or emergency hospital:  
\_\_\_\_\_

By my signature below, I certify that the information above is true and accurate and that: (a) I am a physician licensed to practice medicine in the state where this abortion is to be performed, (b) I have a current and fully paid malpractice insurance policy with the company named above, (c) my license to practice medicine has never been suspended or revoked in this or any other state, (d) I have no claims or judgments against me for medical malpractice, personal injury or wrongful death, and (e) if you are injured during your abortion you will be immediately transferred by ambulance to the emergency facility named above.

**Physician's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_