PATIENT ACKNOWLEDGEMENT OF 24 HOUR NOTIFICATION
State of Georgia Requirement

Patient Name: _____ Birthdate: ____/____/____
LAST FIRST MI

For Medical Personnel only:

Notified		Information provided by			Requested Materials		Date materials picked up or mailed
In Person	By Phone	MD	Qualified Agent	Initials	Yes	No	

I, (printed name) _____, request that an abortion be performed on me.

I certify that:

1. At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or either physician's qualified agent (which could be a patient educator, licensed psychologist, licensed social worker, licensed professional counselor, licensed assistant, physician, or registered nurse) has told me, by telephone or in person,

- the particular medical risks for me associated with the particular abortion procedure that will be used to end my pregnancy;

- the probable gestational age of the embryo or fetus at the time of the abortion;

- the medical risks associated with continuing the pregnancy to term;

- that medical assistance benefits may be available for prenatal care, childbirth and neonatal care;

- that the father will be liable to assist in the support of the child; and

- upon request, you have the right to review the printed or online materials that have been provided by the state of Georgia that describe the fetus and lists agencies that offer alternatives to abortion. This website is: http://health.state.ga.us/wrtk/

I am giving written acknowledgement, as required by the state of Georgia, that I have received this information at least 24 hours prior to the abortion and had the opportunity to ask questions.

Patient Signature: Patient Name (printed): Date: Time:

_____ _____ _____ _____

Day of procedure:

Physician Signature: _____ Date: _____ Time: _____