

ACKNOWLEDGMENT OF STERILIZATION AS A RESULT OF HYSTERECTOMY

THIS FORM MUST BE SIGNED BEFORE SURGERY

I _____ have been informed that I should have a
Patient's Name – Print Or Type

hysterectomy because of medical reasons. I have been advised both orally and in writing by

_____ that as a result I will be sterile (unable to bear children).
Physician's Name – PRINT or TYPE

Patient's Signature

Date

Physician's Signature

Date

Witness' Name– PRINT or TYPE

Witness' Signature

Date