
SUPPLEMENT FOR ABORTION CENTERS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant:
2. Does the Applicant provide patients with:
   (a) Written discharge instructions? [ ] Yes [ ] No
   If Yes, attach a copy of the discharge instructions.
   (b) A contact name and phone number to contact the clinic/center after business hours? [ ] Yes [ ] No
3. Does the Applicant have a contract with an ambulance company for emergency transport? [ ] Yes [ ] No
4. Provide the following information for the past twelve months:

(a)	1st Trimester	13-16 wks gestation	16-20 wks gestation	20+ wks gestation	Total
No. of Surgical Abortions					
Method(s) Used					

(b)	1st Trimester	13-16 wks gestation	16-20 wks gestation	20+ wks gestation	Total
No. of Medical Abortions					
Method(s) Used					

5. Provide the following information estimated for the coming year:

(a) **Type of Visit**	**No. of Estimated Visits**	(b) **In-house Laboratory Testing**	**No. of Estimated Lab Tests**
Counseling	_____	Hematocrits	
Family Planning	_____	Pregnancy Tests	
Gynecological	_____	Rh Tests	
Other (describe)		Urinalysis	
		Other (describe)	

6. Does the Applicant perform ultrasounds prior to any:
   (a) Medical Abortion? [ ] Yes [ ] No
   (b) Surgical Abortion? [ ] Yes [ ] No
7. As part of this Supplement attach the following:
   (a) Procedures on compliance with parent and father notification.
   (b) Procedures and protocols for complications.
   (c) A copy of all Patient Consent Forms used.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.
It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Applicant Title

Signature of Applicant Date