ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Health and Human Services

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

_____

(Recipient or Representative Signature) (Date)

_____

(Interpreter Signature, if required to inform the recipient of the above information) (Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

_____

(Physician Signature) (Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.