



\_\_\_\_\_

Date Time Woman's Signature

\_\_\_\_\_

Name of Guardian (Relationship) Guardian's Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I provided the patient / the patient's guardian\* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

\_\_\_\_\_

Name of Physician Physician's Signature License No.

\* Cross out irrelevant option.