SURGICAL UTERINE EVACUATION

Physician name: _____ CPSID: _____

Facility applying to: _____

Please indicate only the procedures you wish to perform at the above-mentioned facility.

- ☐ Surgical uterine evacuation up to 13 weeks + 6 days. Includes procedures for:
  - ☐ Abortion
  - ☐ Management of miscarriage
  - ☐ Non-viable pregnancy
  - ☐ Retained products of conception
- ☐ Surgical uterine evacuation 14 weeks up to 17 weeks + 6 days. Includes procedures for:
  - ☐ Abortion
  - ☐ Non-viable pregnancy

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Physician signature: _____ Date: _____