FACILITY NAME
PELVIC EXAMINATION CONSENT

Patient Name: ____DOB:________

Physician: ________________________

I understand that my medical care may require a pelvic examination, defined as a manual examination of the organs of the female reproductive system using the provider's gloved hand or instrumentation.

By my signature below I give my express consent to any and all medically appropriate pelvic examinations as defined above to be conducted now or in the future by the above provider, as well as any affiliated health care provider, medical student, or student receiving training as a health care provider that is employed by or contracted by:

Facility Name:____

*Patient Signature: _______________________________Date:_______Time:_______
or legal guardian if patient not 18

Witness Signature:____Date:_______