Sample Suggested Form for Physician

RECEIPT OF NOTICE TO OBSTETRIC PATIENT

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), pursuant to Section 766.316, Florida Statutes, by (insert name of OBGYN GROUP), (the "Physicians Group"), and have been advised that all physicians in the Physicians Group are participating physician(s) in that program, wherein certain limited compensation is available in the event certain types of qualifying neurological injuries may occur during labor, delivery or resuscitation in a hospital. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida 32317-4567, (800) 398-2129.

I specifically acknowledge that I have received a copy of the Brochure prepared by NICA.

DATED this _____ day of _____, 200___.

_____
Signature of Patient

_____
Printed Name of Patient
Social Security No:_____

Attest:

_____
(Nurse or Physician)

Date:_____

Note: This Suggested Form is to be utilized only upon the advice of the Physicians Group's counsel. This form is not a required NICA form.