Falls Church Healthcare Center
900 South Washington Street, Suite 300
Falls Church, Virginia 22046
703 532-2500

Consentimiento Firmado y Notificado Por El Menor No Emancipado Para Commonwealth of Virginia:

Yo, _____(imprima su nombre) , soy el legal

(circule uno) padre, guardian, persona de custodia, familiar cercano de_____
(print name of minor)

y se me ha notificado sobre su intencion de terminar su embrazo y yo le doy consentimiento a que este

procedimiento se realize.

_____ _____.
Firma del padre, guardian, persona de custodia o familiar cercano fecha

Staff Witness:_____

Notarial Statement:
Certificate of Acknowledgement:
City/county of _____Commonwealth of Virginia
Or location:
The foregoing instrument was acknowledged before me this____day of _____, 20_____

By: _____
Name of the parent, guardian, custodian or loco parentis.

Given under my hand this _____day of _____ , 20___

_____
Notary Public

My commission expires _____

Notification Of Authorized Person By Falls Church Healthcare Center:

☐ Authorized person came with minor on _____

☐ Authorized Person notified of intent by telephone attempts: _____; _____;
☐ registered mail date _____ return rcpt rcvd _____
Staff _____