



Notification of Disposition of Fetal Remains

Please be advised that you have choices concerning the final disposition of fetal remains of less than twenty weeks gestation, as provided in the Stephanie Saboor Grieving Parents Act.

You may choose to have burial or cremation by a licensed funeral director or a registered direct disposal establishment, or you may choose to have this health care facility make arrangements under the terms and conditions customarily used by the facility.

The following options are provided for your consideration. Please select one of these options:

_____ I wish to personally arrange for the burial of the fetal remains with a licensed funeral director or registered direct disposal establishment. I understand that I may also choose to have a funeral service. I understand I am responsible for all expenses incurred.

_____ I wish for the health care facility named below to arrange the disposition under the terms and conditions customarily used.

If you do not specify a choice, the health care facility is authorized by law to arrange for the disposition of fetal remains under the terms and conditions customarily used.

Mother (Print or type name) (Signature) (Date)

Name of Medical Facility: _____

Address: _____

City and Zip Code: _____

Name / Title of person presenting form to Mother: _____

Date form presented to Mother _____

A copy of this completed form shall be retained in the mother's facility file and shall be available for review by the Agency for Health Care Administration or the Department of Health.