ABORTION DISPOSITION LOG

State Form 56981 (R / 4-21)
Indiana Department of Health, Division of Acute and Continuing Care
(Pursuant to IC 16-34-3-4)

Name of Clinic: _____ Address *(number and street)*: _____

City: _____ State: _____ ZIP: _____ Page _____ of _____ attached to the burial permit indicated below.

Date of Abortion Date of procedure or Date medication given ***(month, day, year)***	**Medical Record or Patient Identifier**	**Surgical (S) or Drug Induced (D):** ***Enter "S" or "D"***	**Disposition by: Clinic (C) or Patient (P)** ***Enter "C" or "P"***	**Were remains returned by the patient?** ***Yes or No***	**If remains returned by patient, enter date returned.** ***(month, day, year)***	**Are these remains included in the burial transit permit?** ***Yes or No***

I certify that the above listed fetal remains have been included under the Burial Transit Permit and Disposition for Fetal Remains signed by the funeral director named below and dated _____, _____, 20____ *(enter month, day and year)*.

_____ _____
Signature of clinic representative releasing remains Date *(month, day, year)*

I certify that the fetal remains listed as 'yes included in the burial transit permit' were released to me as authorized representative of the funeral director in charge of transportation of remains as indicated on the attached Burial Transit Permit and Disposition for Fetal Remains signed and dated _____, _____, 20____ *(enter month, day and year)*.

_____ _____
Signature of Funeral Director representative Date *(month, day, year)*

_____
Printed Name of Funeral Director representative