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ARIZONA SUPERIOR COURT

MARICOPA COUNTY

Paul A. Isaacson, M.D., on behalf of himself, his staff, and his patients; William Richardson, M.D., on behalf of himself, his staff, and his patients; and the Arizona Medical Association, on behalf of itself, its members, and its members' patients,

Plaintiffs,

v.

State of Arizona, a body politic,

Defendant.

No. _____

VERIFIED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

Plaintiffs, Paul A. Isaacson, M.D., William Richardson, M.D., and the Arizona Medical Association ("ArMA") (collectively, "Plaintiffs"), by and through their attorneys, bring this Complaint against the above-named Defendant, its employees, agents, and successors in office and in support thereof state the following:

PRELIMINARY STATEMENT

1. On November 5, 2024, Arizonans voted overwhelmingly in favor of adopting article II, section 8.1 of the Arizona Constitution (the "Amendment"), establishing and protecting "a fundamental right to abortion" in the Arizona Constitution.[1] Ariz. Const. art. II, § 8.1. A copy of the Amendment is attached hereto as Exhibit A.

2. By the terms of the Amendment, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . [d]enies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means." Ariz. Const. art. II, § 8.1(A)(1).

3. Despite the proven safety of abortion care, the State of Arizona has enacted restrictions subjecting abortion providers and their patients to requirements that do not improve or maintain the health of individuals seeking abortion care. They instead serve only to infringe on pregnant Arizonans' autonomous decision making and restrict, interfere with, and in some cases deny altogether their ability to access abortion care.

4. Plaintiffs challenge several core components of Arizona's burdensome statutory and regulatory scheme that deny, restrict, or interfere with Arizonans' constitutional right to abortion. They include:

[1] *2024 Arizona General Elections Results - Proposition 139 - Right to Abortion*, USA Today, https://www.usatoday.com/elections/results/2024-11-05/race/83101/arizona (last updated November 25, 2024).

a. Statutes that ban the provision of certain pre-viability abortions based on the patient's reasons for seeking the abortion. A.R.S. § 13-3603.02, A.R.S. § 36-2157, A.R.S. § 36-2158(A)(2)(d) and A.R.S. § 36-2161(A)(25) (collectively the "**Reason Ban Scheme**"), attached hereto as Exhibit B;

b. Statutes and regulations that collectively force every patient to make at least two trips to an abortion provider by requiring, at least 24 hours before the abortion, an ultrasound, lab testing, and the provision—orally and in person—of certain state-mandated information. A.R.S. § 36-2153(A), (F), A.R.S. § 36-2158(A), A.R.S. § 36-2156(A), A.R.S. § 36-2162.01, A.R.S. § 36-449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1) (collectively the "**Two-Trip Scheme**"), attached hereto as Exhibit C;

c. Statutes and regulations that ban physicians from providing medication abortion to Arizonans through telemedicine and prohibit sending abortion medications in the mail. A.R.S. § 36-2153(A), A.R.S. § 36-2156(A), A.R.S. § 36-2158(A), A.R.S. § 36-3604, A.R.S. § 36-2160(B), A.R.S. § 36-449.03(D), A.A.C. R9-10-1501(8), and A.A.C. R9-10-1509(A)–(E) (collectively the **"Telemedicine Ban Scheme**"), attached hereto as Exhibit D.

5. The Reason Ban Scheme, the Two-Trip Scheme, and the Telemedicine Ban Scheme (together, the "Challenged Laws" or the "Schemes") individually and collectively fail to further any compelling state interest, as defined by the Amendment. Ariz. Const. art. II, § 8.1(B)(1). Instead, they trample Arizonans' autonomous decision making by, *inter alia*, policing the reasons Arizonans have abortions and violating the fundamental tenets of informed consent. The Challenged Laws also impose unnecessary and harmful delays, requiring some patients to travel hundreds of miles for care, and jeopardizing their ability to access the method

of abortion that is best for them or to keep their abortion confidential. And far from advancing or protecting the health of patients seeking abortion care, they are inconsistent with clinically accepted standards of evidence-based medicine, violate the most basic principles of medical ethics, and inflict significant physical and emotional harm on patients.

6. Additionally, by imposing harsh criminal, civil, and/or licensure penalties, the Challenged Laws penalize abortion providers for assisting their patients in exercising their fundamental right to abortion, in direct contradiction of the Amendment. Ariz. Const. art. II, § 8.1(A)(3).

7. Accordingly, Plaintiffs, individual Arizona physicians who provide abortion care and Arizona's largest physician-led membership organization, seek a declaratory judgment that the Challenged Laws violate the Amendment and permanent injunctive relief to vindicate the fundamental rights guaranteed to all Arizonans under the Arizona Constitution.

JURISDICTION AND VENUE

8. This Court has jurisdiction under A.R.S. § 12-123, A.R.S. § 12-1831, and the Arizona Constitution.

9. Venue is proper under A.R.S. § 12-401.

PARTIES

I. PLAINTIFFS

10. Plaintiff Paul A. Isaacson, M.D., is a licensed, board-certified obstetrician-gynecologist ("OB-GYN"). Dr. Isaacson has been providing safe, high-quality abortion care in Arizona for nearly 30 years. Dr. Isaacson is the co-owner of Family Planning Associates Medical Group ("FPA"), an independent licensed abortion clinic located in Phoenix, where he offers procedural and medication abortion services. Dr. Isaacson's clinic is one of the only medical practices in Arizona that regularly provides abortion care up to 23 weeks and 6 days after the

first day of a patient's last menstrual period ("LMP"). Until the Reason Ban Scheme took effect in July 2022, FPA was the foremost practice in Arizona providing care to patients referred by other physicians and who are seeking abortion care because of medical indications, including following a diagnosis of a fetal condition. Dr. Isaacson teaches in one of the abortion-training programs available to Arizona's OB-GYN resident physicians and is a member of the Arizona Medical Association. Dr. Isaacson brings this suit on his own behalf and on behalf of his staff and his patients.

11. Plaintiff William Richardson, M.D., is a licensed, board-certified OB-GYN and has been providing safe, high-quality abortion care in Arizona for 25 years. Dr. Richardson is a member of the Arizona Medical Association. Dr. Richardson is the owner and medical director of Choices Women's Center, an independent licensed abortion clinic located in Tucson which offers medication abortion services. Dr. Richardson brings this suit on his own behalf and on behalf of his staff and his patients.

12. Plaintiff ArMA is a professional membership organization for Arizona's physicians and physicians-in-training. ArMA's mission is to "foster[] medicine," "champion[] care," and "serv[e] Arizona," which it achieves by "advocat[ing] for physicians and their patients" and "lead[ing] efforts to build a healthier Arizona."[2] The largest organization of physicians in Arizona, ArMA has nearly 4,000 members, including nearly 1,600 medical student, resident, or fellow members. ArMA's members practice throughout the state and in all medical disciplines, including a variety of disciplines that provide reproductive healthcare—i.e., Obstetrics and Gynecology, Maternal and Fetal Medicine, and Family Medicine[3]—and who care

[2] Ariz. Med. Ass'n (ArMA), *About the Arizona Medical Association*, https://www.azmed.org/page/about (last visited May 13, 2025).

[3] *Id.*

in myriad ways for pregnant patients, provide genetic testing and counseling for pregnant patients, and/or provide or refer for pregnancy termination. ArMA's members regularly practice telemedicine for non-abortion healthcare, including other reproductive healthcare, such as prenatal and post-partum care. ArMA's Code of Medical Ethics requires that "physician[s] shall provide competent medical care, with compassion and respect for human dignity and rights," and that "[a] physician shall respect the law and recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."[4] ArMA sues on behalf of itself, its members, and its members' patients.

II. DEFENDANT

13. Defendant State of Arizona is a body politic.

THE CHALLENGED LAWS

I. THE REASON BAN SCHEME

14. The Reason Ban Scheme consists of several interdependent provisions that collectively prohibit providing an abortion if a provider knows that the patient's decision to obtain an abortion is to some uncertain degree motivated by an unclearly defined set of "genetic abnormalities" in the fetus or embryo.

15. The Reason Ban Scheme defines "genetic abnormality" as the "presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression." A.R.S. § 13-3603.02(G)(2)(a).

16. The Reason Ban Scheme creates a class 3 felony punishable by two to 8.75 years of imprisonment for any person who "knowingly . . . [s]olicits or accepts monies to finance . . .

[4] ArMA, *Arizona Medical Ass'n (ArMA) Code of Medical Ethics* (Mar. 31, 2021), https://cdn.ymaws.com/www.azmed.org/resource/resmgr/governance/ArMA_Member_Code_of_Ethics.pdf.

an abortion *because of* a genetic abnormality" of the fetus or embryo. A.R.S. § 13-3603.02(B)(2) (emphasis added); A.R.S. § 13-702(D). The Reason Ban Scheme also creates a class 6 felony punishable by four months to two years of imprisonment for any person who "[p]erforms an abortion knowing that the abortion is *sought solely because of* a genetic abnormality" of the fetus or embryo. A.R.S. § 13-3603.02(A)(2) (emphasis added); A.R.S. § 13-702(D).

17. The Reason Ban Scheme also prohibits abortion care unless the provider first executes an affidavit swearing they have "no knowledge" the pregnancy is being terminated "*because of* a genetic abnormality" of the fetus or embryo. A.R.S. § 36-2157 (emphasis added).

18. The Reason Ban Scheme further prohibits abortion care unless the provider first tells any patient "diagnosed with a nonlethal fetal condition" that Arizona law "prohibits abortion . . . *because of* a genetic abnormality." A.R.S. § 36-2158(A)(2)(d) (emphasis added).

19. The Reason Ban Scheme requires providers to report to the Arizona Department of Health Services ("ADHS") "[w]hether any genetic abnormality . . . was detected at or before the time of the abortion by genetic testing, such as maternal serum tests, or by ultrasound, such as nuchal translucency screening, or by other forms of testing." A.R.S. § 36-2161(A)(25). This is in addition to the requirement that providers ask every patient's "reason for the abortion," including whether the "abortion is due to fetal health considerations," and report any such reason provided. A.R.S. § 36-2161(A)(12).

20. The Reason Ban Scheme does not prohibit abortions in the case of "lethal fetal condition[s]" "diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth." A.R.S. § 13-3603.02(G)(2)(b); A.R.S. § 36-2158(G)(1).

21. In addition to criminal penalties, those who violate any provision of the Reason Ban Scheme risk suspension or revocation of their medical and/or facility license, public censure,

and civil penalties of at least $1,000 and up to $10,000 for each violation found. A.R.S. § 32-1401(27); A.R.S. § 32-1403(A)(2), (A)(5); A.R.S. § 32-1403.01(A); A.R.S. § 32-1451(A), (D)–(E), (I), and (K).

22. The Reason Ban Scheme also broadly imposes liability on any "physician, physician's assistant, nurse, counselor or other medical or mental health professional who knowingly does not report known violations [of the Scheme] to appropriate law enforcement authorities." A.R.S. § 13-3603.02(E).

23. Finally, the Reason Ban Scheme imposes broad civil liability. A.R.S. § 13-3603.02(D).

II. THE TWO-TRIP SCHEME

24. The Two-Trip Scheme consists of a collection of statutory and regulatory provisions that, independently and collectively, require patients to make at least two trips to a healthcare clinic—on days that a physician is present and available—before receiving an abortion:

a. A.R.S. § 36-2156(A)(1) requires a patient to undergo a mandatory ultrasound at least 24 hours before an abortion, regardless of medical necessity or the patient's individual circumstances. *See also* A.A.C. R9-10-1509(A)(4) (incorporating A.R.S. § 36-2156 ultrasound requirement); A.R.S. § 36-2162.01 (reporting requirement for A.R.S. § 36-2156).

b. A.R.S. § 36-2153(A)(1) mandates a patient complete an in-person consultation at least 24 hours before an abortion, during which the physician must orally recite to the patient state-mandated, stigmatizing, and irrelevant information including but not limited to the probable anatomical and physiological characteristics of the fetus at the time the abortion is to be

performed, regardless of the patient's wishes or individual circumstances. *See also* A.A.C. R9-10-1509(E)(1) (incorporating requirements of A.R.S. § 36-2153); A.R.S. § 36-2162.01 (reporting requirement for A.R.S. § 36-2153).

c. A.R.S. § 36-2153(A)(2) also mandates that "the physician who is to perform the abortion, the referring physician or a qualified physician, physician assistant, nurse, psychologist or licensed behavioral health professional to whom the responsibility has been delegated by either physician" recite additional information to the patient, orally and in person, at least 24 hours before an abortion, again regardless of the patient's individual circumstances. This information includes but is not limited to:

- "Medical assistance benefits may be available for prenatal care, childbirth and neonatal care."
- "The father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted."
- "Public and private agencies and services are available to assist the woman during her pregnancy and after the birth of her child if she chooses not to have an abortion, whether she chooses to keep the child or place the child for adoption."

d. A.R.S. § 36-2153(A)(2)(f)–(g) requires a physician to refer patients to a state-created website[5] and pamphlet[6] containing inaccurate, biased, and/or misleading information about abortion at least 24 hours before an abortion.

e. A.R.S. § 36-2158(A) further mandates that a medical provider must provide certain additional information to a patient, orally and in person, at least 24 hours before an abortion if the patient is seeking abortion care after the fetus has been diagnosed with a lethal or nonlethal condition. *See also* A.A.C. R9-10-1509(E)(1) (incorporating requirements of A.R.S. § 36-2158).

f. A.R.S. § 36-449.03(D)(3) requires the promulgation of rules regarding laboratory tests for Rh typing, which in turn require that, prior to an abortion, all patients receive a test for Rh typing "unless the patient provides written documentation of blood type acceptable to the physician." A.A.C. R9-10-1509(A)(3)(b); *see also* A.A.C. R9-10-1509(B) (requiring providers to offer treatment based on Rh typing results within 72 hours after abortion and document patient refusal); A.R.S. § 36-449.03(G)(5) (same).

25. A physician who knowingly violates A.R.S. § 36-2153, A.R.S. § 36-2156, or A.R.S. § 36-2158(A) is subject to license suspension or revocation, *see* A.R.S. § 36-2153(J), (L); A.R.S. § 36-2156(B), (D); A.R.S. § 36-2158(C), as well as other civil penalties, *see* A.R.S. § 36-2153(K); A.R.S. § 36-2153(L). An abortion clinic that is not in "substantial compliance" with the Rh typing requirement may be subject to a range of civil penalties, including, among others,

[5] Ariz. Dep't of Health Servs. (ADHS), *Woman's Right to Know Act – Home*, https://www.azdhs.gov/prevention/womens-childrens-health/informed-consent/index.php#right-to-know-home (last visited May 13, 2025).

[6] *Id.*

a fine of to $1,000 per violation, per patient impacted by the violation, reduction or termination of services, and suspension or revocation of the clinic's license. A.R.S. § 36-449.03(J)(1).

III. THE TELEMEDICINE BAN SCHEME

26. The Telemedicine Ban Scheme consists of a collection of statutory and regulatory provisions that independently and collectively prohibit medical providers from providing abortion through telemedicine.

27. Arizona law expressly bans the use of telemedicine for abortion care, providing in A.R.S. § 36-3604(A) that "[a] health care provider shall not use telehealth to provide an abortion."

28. For medication abortions, A.R.S. § 36-449.03(D) and the statute's implementing regulation, A.A.C. R9-10-1509, require patients to travel to a clinic and undergo an in-person physical examination performed by a physician, which must include a bimanual examination, an ultrasound, and various laboratory tests. A.R.S. § 36-449.03(D); A.A.C. R9-10-1509(A)–(D); *see also* A.A.C. R9-10-1501(8).

29. A.R.S. § 36-2156(A), which requires an ultrasound at least 24 hours before an abortion, regardless of medical necessity, and A.R.S. §§ 36-2153(A) and 36-2158(A), which require patients to obtain state-mandated counseling in person, effectively preclude telemedicine for abortion because they compel patients to schedule at least two in-person visits to an abortion provider as a condition of obtaining care.

30. Lastly, A.R.S. § 36-2160(B) imposes a mailing ban that prohibits "a manufacturer, supplier or physician or any other person . . . from providing an abortion-inducing drug via courier, delivery or mail service." An "abortion-inducing drug" is defined as "a medicine or drug or any other substance used for a medication abortion." A.R.S. § 36-2160(D).

31. Due to this mailing ban, even if a patient seeking medication abortion could meet virtually with their provider for a telehealth consultation, they would still have to make an unnecessary trip to pick up their abortion medication in person. Only three other states enforce such a mailing ban.[7]

32. A physician who knowingly violates the express ban on the use of telemedicine for abortion "commits an act of unprofessional conduct and is subject to license suspension or revocation[.]" A.R.S. § 36-3604(B).

33. A clinic provider who violates the mailing ban may be fined up to $1,000 per violation, per day and per patient affected. A.R.S. § 36-431.01.

34. A licensed abortion clinic that is not "in substantial compliance with" the requirements to conduct an in-person physical exam, ultrasound, or laboratory tests may be fined up to $1,000 per violation per day by ADHS. A.R.S. § 36-449.03(J)(1); A.R.S. § 36-431.01. ADHS may also "[i]mpose an intermediate sanction," such as "immediate restriction of admissions or readmissions, selected transfer of patients out of the facility, reduction of capacity and termination of specific services, procedures, practices or facilities." A.R.S. § 36-449.03(J)(1); A.R.S. § 36-427. In addition, ADHS may suspend, revoke, or deny a facility license or bring an action to enjoin the future operation or maintenance of the clinic. *See* A.R.S. § 36-430.

[7] The others are Florida, Texas, and Oklahoma, where strict abortion bans are currently in effect. Fla. Stat. § 390.0111; Okla. Stat. tit. 63, § 1-756.3; Tex. Health & Safety Code Ann. § 171.063; *see also* Guttmacher Inst., *State Laws and Policies: Medication Abortion*, https://www.guttmacher.org/state-policy/explore/medication-abortion (last updated Apr. 23, 2025).

FACTUAL ALLEGATIONS

I. THE ABORTION AMENDMENT

35. The Amendment establishes and protects "a fundamental right to abortion" in Arizona. Ariz. Const. art. II, § 8.1.

36. By the terms of the Amendment, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . denies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means." Ariz. Const. art. II, § 8.1(A)(1).

37. By the terms of the Amendment, a "'[c]ompelling state interest' means a law, regulation, policy or practice that meets *both* of the following:"

a. First, it "is enacted or adopted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine."

b. Second, it "[d]oes not infringe on that individual's autonomous decision making."

Ariz. Const. art. II, § 8.1(B)(1)(a)–(b) (emphasis added).

38. Thus, the Amendment permits only those regulations of pre-viability abortion that *both* protect patient autonomous decision making *and* make the abortion safer (according to clinically accepted standards) for the person seeking an abortion, using the least restrictive means.

39. The Amendment further prohibits the State from "enact[ing], adopt[ing] or enforc[ing] any law, regulation, policy or practice that . . . penalizes any individual or entity for *aiding or assisting* a pregnant individual in exercising the individual's right to abortion." Ariz. Const. art. II, § 8.1(A)(3) (emphasis added).

II. ABORTION AND PRE-NATAL CARE IN ARIZONA

A. The Abortion Decision

40. Approximately one in four women in this country will have had an abortion by age forty-five.[8]

41. The decision to have an abortion is one of the most personal and intimate decisions a person can make about their body, their health, and their life. That decision is informed by a combination of diverse, complex, and interrelated factors that are intimately tied to an individual's values, beliefs, culture, religion, health status, reproductive history, familial situation, resources, economic stability, and life plans.

42. There is no typical abortion patient. Some people have abortions because they decide it is not the right time to have a child or to add to their existing families. Others have abortions because they do not wish to have a child at all.

43. Like most abortion patients in the United States, the majority of Arizona abortion patients in 2023 had at least one child, and nearly 30% had two or more children.[9] These pregnant people and their families must consider how another child will impact their ability to care for the children they already have. For some, an additional child can place economic and emotional strain on a family that they are simply unable to bear.

44. For some people, continuing a pregnancy and having a child will make it too difficult for them to pursue educational or career goals and support themselves and their families

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[8] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008 - 2014*, 107 Am. J. Pub. Health 1904, 1907 (2017).

[9] ADHS, *Abortions in Arizona: 2023 Abortion Report* 11 (Dec. 18, 2024), https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2023-arizona-abortion-report.pdf [hereinafter "2023 ADHS Abortion Report"]; s*ee also* Katherine Kortsmit et al., *Abortion Surveillance - United States, 2019*, 70(9) CDC Morbidity & Mortality Weekly Report 1 (2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm (almost 60% of women who obtained an abortion in 2019 already had at least one child).

going forward. Indeed, nationwide, new mothers' earnings drop after they give birth and often do not fully return to their pre-pregnancy earnings paths.[10]

45. Some people seek abortion care because of a fetal condition.

46. Others seek abortion care because continuing their pregnancies would threaten their health or life, or because they conclude that pregnancy, childbirth, and an additional child may exacerbate an already difficult and dangerous situation with an abusive partner.

B. Abortion Safety & Methods

47. A typical full-term pregnancy is approximately 40 weeks.

48. In a typical pregnancy, viability does not occur until, at the earliest, approximately 23 or 24 weeks LMP.

49. In Arizona, abortion is legal until viability. A.R.S. § 36-2301.01. After viability, abortion is legal when "necessary to preserve the life or health of" the pregnant person, A.R.S. § 36-2301.01(A)(1), but there are no providers of post-viability abortions in Arizona.

50. Abortion is one of the safest medical interventions in the United States.

51. Serious complications from abortion care are extremely rare, occurring in fewer than 1% of abortions.[11]

52. The risk of death associated with abortion is also exceedingly low. For example, it is far lower than the risks associated with other routine medical procedures, such as colonoscopies and tonsillectomies.[12]

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[10] *See* Danielle H. Sandler & Nicole Szembrot, *New Mothers Experience Temporary Drop in Earnings*, U.S. Census Bureau (Jun. 16, 2020), https://www.census.gov/library/stories/2020/06/cost-of-motherhood-on-womens-employment-and-earnings.html.

[11] *See* Nat'l Acads. of Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, 77 (2018), https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states [hereinafter "National Academies Safety Report"].

[12] *See id.* at 75.

53. Abortion is also far safer than its only alternative—trying to continue a pregnancy to term and childbirth.

54. The starkest risk of carrying a pregnancy to term is death, and pregnancy is growing more dangerous. In Arizona, women died from pregnancy-related causes at a ratio of 26.3 per 100,000 live births in 2018–2019, the most recent years for which ADHS has published data.[13] During that period, 43 women died of pregnancy-related causes in Arizona; 0 died from abortion.[14]

55. Pregnancy is significantly more dangerous for American Indian/Alaska Native[15] and Black or African American women in Arizona. In Arizona, American Indian/Alaska Native women account for 5.8% of live births in the state, but 15.1% of pregnancy-associated deaths. Black or African American women account for 5.9% of live births in the state, but 14.3% of pregnancy-related deaths.[16]

56. Nationally, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among patients giving birth than among those having abortions.[17]

57. Serious long-term medical and physical consequences short of death may arise from carrying a pregnancy to term and giving birth, even for those who are healthy and have

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[13] *See* ADHS, *Maternal Mortality in Arizona, 2018-2019*, 19 (Jan. 2024), https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/mm-2018-2019.pdf; *see also id.* at 11 (women died from pregnancy-related causes in Arizona at a ratio of 18.3 per 100,000 live births in 2016-2017).

[14] *Id.* at 20.

[15] Plaintiffs use the term "American Indian/Alaska Native" here because that is the term used in ADHS statistics.

[16] ADHS, *Maternal Mortality in Arizona, 2018-2019, supra* note 13, at 28.

[17] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstetrics & Gynecology 215 (2012).

uncomplicated pregnancies. Pregnancy stresses most major organs and involves profound and long-lasting physiological changes, including on a pregnant person's health and ability to have children in the future. For someone with a medical condition caused or exacerbated by pregnancy, the risks of complications are increased.

58. Two types of abortion are commonly available in Arizona: medication abortion and procedural abortion.

59. Medication abortion is generally available in the first 11 weeks LMP. It typically entails two prescription medications, mifepristone and misoprostol. Mifepristone, also known as "RU-486" or by its commercial name Mifeprex, blocks the actions of progesterone, which is necessary to sustain a pregnancy, and increases the efficacy of the second medication in the regimen, misoprostol. Misoprostol is generally taken within 48 hours after the mifepristone, and causes the uterus to contract and expel its contents, which occurs while the patient is at home or another location of their choosing, in a process no different than a spontaneous miscarriage. Staff schedule a follow-up visit within two weeks of when mifepristone is provided, though these appointments are often cancelled by the patient or done by phone.

60. Approximately 59% of clinician-provided abortions provided in Arizona in 2023 were medication abortions.[18] This is in line with national trends: as of 2023, medication abortion accounted for 63% of all clinician-provided abortions in the United States.[19]

[18] Rachel K. Jones and Amy Friedrich-Karnik, *Policy Analysis: Medication Abortion Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020*, Guttmacher Inst. (Mar. 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020; Guttmacher Inst., *Arizona: Monthly Abortion Provision Study*, https://www.guttmacher.org/monthly-abortion-provision-study (last visited May 13, 2025).

[19] *Id.*

61. The rate of clinically significant complications for medication abortion is exceedingly low, regardless of whether it is provided in person or by telemedicine. Indeed, the reported low risks of medication abortion are similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications.[20] For example, mifepristone has a safety profile comparable to that of an NSAID, like ibuprofen.[21]

62. Procedural abortion[22] involves the use of aspiration (gentle suction) and/or instruments to evacuate the uterus. Depending on the stage of pregnancy, procedural abortion takes approximately five to ten minutes to complete.

C. Fundamental Principles of Informed Consent, Decisional Autonomy, and Bodily Integrity

63. Obtaining informed consent prior to providing medical treatment is the standard of care and an ethical imperative of medical practice generally, as well as a legal requirement for all physicians practicing medicine in Arizona. *Duncan v. Scottsdale Med. Imaging, Ltd.*, 70 P.3d 435, 439 (Ariz. 2003) (recognizing negligence claims for lack of informed consent).

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[20] National Academies Safety Report, *supra* note 11, at 58.

[21] *See id.*; *see also* Jack Resneck Jr., *Reducing Access to Mifepristone Would Harm Patients*, Am. Med. Ass'n (Mar. 25, 2024), https://www.ama-assn.org/about/leadership/reducing-access-mifepristone-would-harm-patients.

[22] Though sometimes called "surgical abortion," this is a misnomer. *See* Am. Coll. of Obstetricians & Gynecologists (ACOG), *ACOG Position Statement: Definition of "Procedures" Related to Obstetrics and Gynecology* (Mar. 2023), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology ("A procedure is a short interventional technique that includes . . . non-incisional diagnostic or therapeutic intervention through a natural body cavity or orifice"); ACOG, *ACOG Guide to Language and Abortion* 1 (Oct. 2024) https://www.acog.org/contact/media-center/abortion-language-guide ("The abortion procedure is not a surgery. Referring to it as a procedure is clinically accurate."); Am. Med. Ass'n (AMA), *AMA Code of Medical Ethics 4.2.7 Abortion*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2023-08/4.2.7.pdf (last visited May 13, 2025) (describing abortion as "a safe and common medical procedure").

64. Central tenets of medical ethics provide that the physician may not act upon the patient without the patient's informed consent; that the physician must respect the patient's autonomy; that the physician must act in the patient's best interests; and that the physician must avoid causing unnecessary harm to patients.

65. The American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading professional association of obstetricians and gynecologists, instructs in its Code of Ethics that "respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental," and "the welfare of the patient must form the basis of all medical judgments."[23]

66. Informed consent is the process by which a healthcare provider educates a patient about the nature and purpose, risks and benefits of, and alternatives to, a medical procedure or intervention to ensure that the patient can make a fully informed and voluntary decision about whether to undergo the procedure or intervention.

67. Informed consent serves the important medical ethics principle of patient autonomy by ensuring that the patient's dignity and right to self-determination is respected. Informed consent is also a process designed and intended to build trust between the patient and their medical provider.

68. The standard of medical care before starting any abortion is for healthcare providers to counsel their patients to be certain in their decision to terminate the pregnancy, consistent with their general ethical duty of obtaining informed consent for medical procedures.

[23] ACOG, *ACOG Code of Professional Ethics* 1–2 (Dec. 2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf?rev=efb878bf939d46b1a05f8775eff49c0b.

69. To ensure informed consent, fundamental principles of medical ethics require that healthcare providers exercise their clinical judgment to provide medically relevant and accurate information about the nature and purpose of the proposed course of treatment; its risks and benefits, as well as its alternatives; and to answer any questions the patient may have.

70. The extent and nature of this information should be tailored to the patient's particular needs, values, preferences, and concerns. The American Medical Association's ("AMA") Code of Medical Ethics, which is widely recognized as a comprehensive ethics guide for physicians, dictates that the informed consent process should take account of a patient's individual circumstances and physicians should tailor the information they provide to the patient's needs and expectations.[24]

71. For example, patients vary widely in their preferences concerning the level of detail they wish to receive related to a medical condition or intervention and the manner in which the information is communicated to them. Medical images and descriptions are a prime example of this; some patients believe they will benefit from seeing medical images and others do not. Similarly, ACOG states that "[t]he highest ethical standard for adequacy of clinical information requires that the amount and complexity of information be tailored to the desires of the individual patient and to the patient's ability to understand this information."[25]

72. To make informed consent possible, patients must be given medically accurate, necessary information about the treatment or procedure so that they can make the right decisions for themselves. Patients rely upon their medical providers to give them accurate, relevant

[24] AMA, *Code of Ethics, Opinion 2.1.1, Informed Consent*, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (last visited May 13, 2025).

[25] ACOG, *ACOG Committee Opinion No. 819* (Feb. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.

information, and when providers present information to patients about the treatment options that are available and their expected outcomes, patients expect the information to be grounded in evidence and the medical provider's best medical judgment.

73. It is antithetical to the purpose of informed consent, and a violation of medical ethics, for a medical provider to give misleading or inaccurate information to a patient during the informed consent process. Doing so would undermine the patient's ability to make an informed decision about whether to undergo a particular medical treatment, thereby misinforming the patient at the very moment she requires a clear, accurate presentation of pertinent information so that she can decide on a course of treatment. For the same reasons, the information provided should be unbiased and non-stigmatizing.[26]

D. Availability of Abortion in Arizona

74. There are only seven licensed abortion clinics in the state and many of those facilities provide abortion only during the early weeks of pregnancy. These clinics are located in Phoenix, Tucson, and Flagstaff, leaving large swaths of the state without any known providers.

75. In 2023 alone, there were nearly 13,000 total abortions in the state of Arizona, the vast majority of which were provided by these seven facilities.[27]

76. The only known providers of abortion care beyond 16 weeks LMP are in Phoenix.

77. A small number of abortions are also provided in hospitals, though this care is typically limited to health- and life-saving abortions, and complex cases.

78. Additionally, although physicians can provide medication abortion and procedural abortion in their private practices, Arizona law limits this care to five abortions per month. *See* A.R.S. §§ 36-449.01–.02 (requiring facilities providing more than five first trimester abortions

[26] AMA, *Code of Ethics, Opinion 2.1.1, supra* note 24.

[27] *See* 2023 ADHS Abortion Report, *supra* note 9, at 4.

or any second or third trimester abortions each month to be licensed as abortion clinics). As a result, the availability of abortion care outside a licensed clinic is generally limited to physicians' existing patients.

79. Due to structural barriers to accessing reproductive healthcare, the vast majority of abortion patients are poor or low-income.[28]

80. Furthermore, approximately two-thirds of abortion patients in Arizona are American Indian/Alaska Native and/or people of color, though these populations account for approximately half of Arizona's total population.[29]

81. Medically unnecessary laws that make abortion more difficult, if not impossible, to obtain therefore disproportionately impact American Indian/Alaska Native people, people of color, people with low incomes, young people, and people living in rural areas—that is, those who already face barriers to accessing healthcare.[30]

[28] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute, 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[29] ADHS, *Abortions in Arizona: 2022 Abortion Report*, 8 (Dec. 5, 2023), https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2022-arizona-abortion-report.pdf; U.S. Census Bureau, *QuickFacts: Arizona*, https://www.census.gov/quickfacts/AZ (last visited May 22, 2025).

[30] Racial disparities in abortion rates are attributable in part to the fact that "Black, Hispanic, American Indian and Alaska Native (AIAN), and Native Hawaiian or Pacific Islander (NHPI) women have more limited access to healthcare, which affects their access to contraception and other sexual health services that are important for pregnancy planning." Latoya Hill et al*., What are the Implications of the Dobbs Ruling for Racial Disparities?,* Kaiser Fam. Found. (Apr. 24, 2024), https://www.kff.org/womens-health-policy/issue-brief/what-are-the-implications-of-the-dobbs-ruling-for-racial-disparities/.

E. Telemedicine Safety and Benefits

82. Medication abortion is safely and effectively provided via telemedicine in the majority of states where abortion is legal.[31] Over the past decade, medication abortion via telemedicine has been provided in numerous states, including, for example, California, Colorado, Connecticut, Delaware, Hawai'i, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, New Jersey, Nevada, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, Wyoming, and the District of Columbia.[32]

83. Telemedicine is a safe, cost-effective, and common way to deliver medical care. It refers to the use of secure audio and/or video to deliver a medical service when patients and healthcare providers are not in the same physical location.

84. In many cases, telemedicine is an equally effective method of healthcare administration. It also saves clinicians and patients unnecessary, time-consuming, and expensive travel.

85. Moreover, telemedicine patients have comparable clinical outcomes to those who receive face-to-face care, with equivalent success rates and a low prevalence of adverse events.

86. Arizona has long used telemedicine to expand access to healthcare. More than three decades ago, the Arizona legislature established one of the nation's first networks of facilities with telemedicine capabilities—the Arizona Telemedicine Program ("ATP"). Today,

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[31] *See* Reprod. Health Initiative for Telehealth Equity & Solutions, *State of Telehealth Medication Abortion (TMAB)* (Apr. 27, 2025), https://www.rhites.org/maps#state-info-section (reporting that Arizona is one of just six states that permits abortion but bans telemedicine for abortion).

[32] Kaiser Family Found., *Abortion in the United States Dashboard, Telehealth Availability*, https://tinyurl.com/yefchdaf (last updated May 7, 2025).

ATP is an award-winning leader in the field and allows physicians to diagnose, consult, and treat patients from remote locations.

87. The use of telemedicine in Arizona has expanded patients' access to care. As of 2014, ATP was providing care in over 60 specialties and had facilitated over 1.3 million services through its network. And as of 2015, ATP had expanded to 160 sites throughout the state. Additionally, a study from July 2021 through July 2022 revealed that more than one in five Phoenix-area households are using telehealth services, and "usage is even higher among the aging population, women, lower-income brackets, Black communities, and those who are more likely to report depression and difficulties with physical mobility."[33]

88. ATP has focused on rural access and cost savings from its inception. Arizona is the sixth-largest state in the country by land area, but it consists of only 15 counties, 13 of which are considered rural. The Arizona Legislature founded ATP, in part, to provide accessible, top-quality healthcare to Arizonans in geographically isolated or underserved communities, including Indigenous populations. Telemedicine, and ATP in particular, are generally praised for improving access to expert healthcare (especially in rural or other sparsely populated areas), facilitating consistent management of chronic diseases, and reducing costs due to improved efficiency, shared staffing, and diminished travel and time away from work or school.

89. In 2021, Arizona passed H.B. 2454—the most expansive and comprehensive telemedicine legislation in the country—making telemedicine a permanent feature of Arizona's healthcare system. Among other things, the Arizona Legislature enacted a telemedicine parity law, which requires private health plans to cover healthcare services when delivered via telemedicine to the same extent the service is covered when provided in person unless the weight

[33] Amanda Hagerman, *Who is Using Teleheath?*, Goldwater Inst. (Jan. 31, 2024), https://www.goldwaterinstitute.org/policy-report/who-is-using-telehealth/.

of evidence (based on practice guidelines, peer-reviewed clinical publications, research, or recommendations from the Telehealth Advisory Committee on Telehealth Best Practices) demonstrates that the service cannot appropriately be provided via telehealth. A.R.S. § 20-1057.13(A). Many of the telemedicine services that must be covered to the same extent as in person services—such as trauma, burns, cardiology, pulmonology, infectious diseases, and neurologic diseases (including strokes)[34]—have higher risks of complications than abortion care.

90. In all medical contexts except abortion, Arizona law permits physicians to use telemedicine to provide consultations and treatment.

91. A telemedicine abortion is very similar to an in-person medication abortion. With in-person medication abortion, the patient typically takes mifepristone at the clinic, then goes home or to a location of their choosing and takes the misoprostol later. Clinic staff then schedule a follow-up visit within two weeks.

92. In a telemedicine setting, the physician would communicate with the patient via two-way, secure audio and/or video and, after reviewing and establishing the patient's eligibility for care, prescribe the necessary medications. The patient would then use the prescription to order the medications for delivery via a mail-order pharmacy to their home or other location of their choosing.[35]

93. The patient would take the mifepristone at a time and location of their choosing and, as with an in-person medication abortion, take the misoprostol within 48 hours. The

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[34] *See* Ariz. Health Care Cost Containment Sys., Telehealth Advisory Comm., *Audio-Only Recommendations: House Bill 2454 Report* (2021), https://www.azahcccs.gov/AHCCCS/Downloads/TelehealthAdvisoryCommittee/Agendas/TAC_AudioOnlyRecommendations-HOUSEBILL2454Report2021Final.pdf.

[35] Although both mifepristone and misoprostol can legally be obtained from brick-and-mortar pharmacies, pharmacies usually do not stock mifepristone. Additionally, patients, especially those in small communities, often prefer to receive their medications by mail for privacy reasons.

provider would also give the patient a toll-free number to call if the patient has questions during or after the medication abortion process and to schedule a follow-up telehealth appointment.

94. According to ACOG's clinical standards for medication abortion, clinicians can safely and effectively provide medication abortion to eligible patients without an ultrasound examination or in-person testing.[36]

95. Guidelines and practices for performing medication abortion in this manner via telemedicine have been successfully developed and deployed in the United States since at least 2008.

96. The latest data, collected from more than 6,000 patients in 20 states, shows that "[t]elehealth medication abortion is effective, safe, and comparable to published rates of in-person medication abortion care."[37]

97. Complications from medication abortion are rare, and because the second set of pills used in medication abortion, misoprostol, is taken outside a provider's office, such complications would most commonly occur after the patient has left the office. In other words, such events would occur outside of the providers' office whether medication abortion is provided in person or by telemedicine.

98. If not for the Telemedicine Ban Scheme, Plaintiff Dr. Richardson would, using telemedicine, follow the same procedures as if the patient were physically present in a clinic. These procedures include having a qualified healthcare provider (1) confirm the patient's pregnancy; (2) collect all necessary information to ensure that a medication abortion is an appropriate course of treatment (such as ensuring that the pregnancy is not ectopic); (3) provide

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[36] ACOG, *Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation* (Oct. 2020, reaff'd 2023) [hereinafter "ACOG Medication Abortion Practice Bulletin"].

[37] Ushma D. Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion in the United States*, 30(4) Nature Med. 1191 (2024).

the patient with necessary information regarding the abortion; and (4) prescribe the necessary medication.

F. Impact of Delayed Abortion Care

99. Although abortion is one of the safest medical interventions in the United States, and always safer than continuing the pregnancy to term, there is an incremental but continuous increase in the risk level and complexity of abortion care as pregnancy progresses.

100. In addition, the cost of an abortion typically increases as pregnancy progresses and the procedure becomes more complex. As a result, unnecessary delays may lead to higher total costs that in turn may lead to further delays as patients struggle to save additional money to cover their care.

101. When patients are forced to travel long distances to reach an abortion provider, they often must delay until they are able to secure time off from work and enough money to pay for not only the abortion itself, but also transportation, lodging, childcare, and/or the cost of missing work. When they are forced to make multiple trips—with each trip potentially taking multiple days—these costs can increase, along with delay.

102. Delays can also push patients past the gestational point at which medication abortion is available, resulting in patients being denied access to medication abortion and requiring them to instead undergo a more invasive procedure.

103. There are many reasons a person may have a strong preference for a medication abortion over a procedural abortion. For some patients with certain medical conditions, medication abortion is medically preferable. Other people strongly prefer medication abortion because it can offer privacy and control. As described *supra*, a medication abortion in effect induces a process indistinguishable from a spontaneous miscarriage, making it far easier to keep the abortion private, including from an abusive partner.

104. Medication abortion via telemedicine provides even further privacy protections by eliminating the need for patients to take multiple out-of-town trips and ensuring medications can be ordered and received in a safe, private location.

105. People who are survivors of sexual abuse or other forms of intimate-partner violence may also strongly prefer medication abortion because it does not require the insertion of instruments into the vagina.

106. Remaining pregnant longer than necessary also poses risks to an individual's physical and mental health, as well as to the stability and well-being of their family, including their existing children.

107. Remaining pregnant longer than necessary can increase health risks for patients with underlying health problems. Pregnancy can exacerbate the symptoms of diabetes, hypertension, autoimmune disorders, cardiac disease, and mental health conditions. It can also trigger the onset of new conditions, including, *inter alia*, hyperemesis gravidarum (severe nausea and vomiting), severe depression, and gestational diabetes.

108. In sum, when a patient has made the decision to have an abortion, delaying their ability to do so can limit their healthcare options and/or cause a substantial toll on their physical, emotional, and psychological health.

G. Screening for, and Diagnosis of, Fetal Conditions During Prenatal Care

109. Offering genetic screening and testing to pregnant patients is standard medical practice. Likewise, ultrasound screening for structural (or "morphological") indications of fetal conditions is standard pregnancy care.

110. Joint practice bulletins from ACOG and the Society of Maternal-Fetal Medicine ("SMFM")—the leading professional organization for physicians and scientists focused on high risk maternal and/or fetal issues—that provide guidelines to aid physicians in meeting

professional standards and providing quality care emphasize that "each pregnant patient should be counseled in each pregnancy about options for testing for fetal chromosomal" conditions.[38]

111. Chromosomal screening and/or diagnostic testing occurs only after complete pre-test counseling and upon "patient choice based on provision of adequate and accurate information, the patient's clinical context, accessible healthcare resources, values, interests, and goals. All patients should be offered both screening and diagnostic tests, and all patients have the right to accept or decline testing after counseling."[39]

112. Testing capabilities continue to evolve and today there are a variety of testing options to attempt to detect a wide range of clinically significant fetal genetic conditions. Screening tests provide preliminary information about likelihood or risk, and do not identify with certainty any condition. Diagnostic tests, which can determine whether a given condition is present in the fetus, take time (including for the cultivation of cells) and may only be available later in pregnancy.

113. The standard ultrasound testing that pregnant patients in prenatal care receive at 18–22 weeks LMP is used to assess fetal development and can identify unusual structural development. These structural issues may or may not be related to a genetic cause or a particular genetic condition.

114. All of this prenatal screening and testing aims to provide additional information to physicians and their patients to guide pregnancy management: testing can identify the presence

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[38] ACOG & SMFM, *Practice Bulletin No. 226: Screening for Fetal Chromosomal Abnormalities* (May 2016) [hereinafter "Screening Bulletin"], https://www.natera.com/wp-content/uploads/2021/04/ACOG-PB-226.pdf; *see also* ACOG & SMFM, *Practice Bulletin No. 162: Prenatal Diagnostic Testing for Genetic Disorders* (Mar. 2016) [hereinafter "Diagnostic Bulletin"], https://s3.amazonaws.com/cdn.smfm.org/publications/223/download- f5260f3bc6686c15e4780f8100c74448.pdf.

[39] Screening Bulletin at e1.

of disorders for which prenatal treatment may provide benefit; help optimize maternal and neonatal outcomes by ensuring the appropriate location and staff for delivery; and inform patients' consideration of future steps, including termination (if that is something the patient is considering) or how best to manage the birth and continued care of a child with needs that may be especially significant.

115. As ACOG and SMFM Clinical Management Guidelines emphasize, both "[p]retest and posttest counseling [are] essential."[40]

116. This counseling about fetal testing is provided by, for example, patients' OB/GYNs, MFMs, and/or genetic counselors and includes detailed information about the conditions at issue, is responsive to patient questions and concerns, and does not direct or attempt to determine patient decision making.[41] The nondirective approach to counseling is central to and used in many aspects of OB/GYN care and is one in which practitioners in OB/GYN care are well versed.

117. Pregnant patients may have misconceptions about fetal conditions or little information about them before testing. Pre- and post-test counseling enables patients to base any decisions on available medical facts and case histories. Without that counseling, they may exaggerate the significance or likely consequences of a given condition or confuse it with other genetic and/or structural manifestations. This counseling ensures that "patients realize there is a broad range of clinical presentations, or phenotypes, for many genetic disorders and that the results of genetic testing cannot predict all outcomes."[42]

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[40] Screening Bulletin at e2.

[41] *See* Screening Bulletin at e9 ("Counseling should be performed in a clear, objective, and nondirective fashion, allowing patients sufficient time to understand and make informed decisions regarding testing" and their pregnancy.); *see also* Diagnostic Bulletin.

[42] Diagnostic Bulletin at 1.

118. Depending on the condition, patients may also participate in counseling regarding risk to future pregnancies or testing of potentially affected family members. Counseling also includes information about potential care resources in the community for the patient, for other family members, and for the child.

119. If the patient wishes to discuss and/or proceed with an abortion, post-test counseling includes information about that option. This post-test counseling would also include information about where to find abortion care and, often, communication between the two physicians concerning the transfer of care.

120. The prognosis for fetal conditions that are or might be present is extremely varied, both among different conditions and within any given one. Medical advances are making some fetal structural issues treatable in the fetal and neonatal periods, but there is a wide range of outcomes even where attempted treatment is possible. Some are invariably incompatible with sustained life, but even for those, there may be considerable uncertainty as to how long a child born with the anomaly may live.

121. Patients who were experiencing a wanted pregnancy but then decide after fetal testing to terminate the pregnancy are often devastated and quite emotional about that turn of events, and often rely on their physicians and other healthcare providers, including mental healthcare providers, for support. They commonly volunteer information about the testing and decision making they have been through to physicians and others involved in subsequent care.

III. THE CHALLENGED LAWS VIOLATE THE AMENDMENT

122. The Reason Ban, Two-Trip, and Telemedicine Ban Schemes each independently infringe the right to abortion, as guaranteed by article II, section 8.1 of the Arizona Constitution.

123. In addition, all three Schemes have similar and/or overlapping requirements such that enjoining only isolated provisions of any of the Schemes would be insufficient to address the constitutional harms the Schemes inflict.

A. The Reason Ban Scheme Denies, Restricts, and Interferes with Access to Abortion

124. The Reason Ban Scheme explicitly prohibits and criminalizes providing certain pre-viability abortions. As such, it cannot survive constitutional scrutiny.

125. To avoid the severe criminal, professional, and civil penalties under the Reason Ban Scheme, Plaintiff Physicians have no choice but to turn away any patient who reveals that they are or may be seeking abortion care wholly or in part for a prohibited reason.

126. By explicitly targeting pregnant people who decide to have a pre-viability abortion after fetal genetic screening or diagnostic testing and denying, restricting, or interfering with that decision, the Reason Ban Scheme, by definition, fails to advance a compelling state interest because it infringes on an individual's autonomous decision making. *See* Ariz. Const. art. II, § 8.1.

127. The Reason Ban Scheme also fails to advance a compelling state interest because it does not "improv[e] or maintain[] the health of an individual seeking abortion care" and is not "consistent with accepted clinical standards of practice and evidence-based medicine." Ariz. Const. art. II, § 8.1(B)(1)(a)–(b).

128. For example, according to ACOG, "[r]estricting abortions on the basis of a woman's reason for needing one is not medically appropriate and endangers the health of women."[43]

[43] Mark DeFrancesco, *ACOG Statement on Abortion Reason Bans*, ACOG (Mar. 10, 2016), https://www.acog.org/news/news-releases/2016/03/acog-statement-on-abortion-reason-

129. Moreover, the Reason Ban Scheme chills patients from sharing certain information with their abortion providers, including communications from other healthcare providers involved in their care, out of fear that such information could prevent them from getting care due to the Reason Ban Scheme.

130. Cutting off open and honest communication between patients and their providers about fetal testing and fetal conditions is contrary to accepted clinical standards governing prenatal care, as well as fundamental principles of medical ethics, informed consent, and the integrity of the patient-physician relationship. And gagging abortion patients from speaking with their medical providers puts their health and well-being in jeopardy and strips them of their ability to fully participate in the informed consent process.

131. The patient-provider relationship is irreparably harmed when patients cannot speak openly with their provider about their pregnancy intentions, genetic testing, or a possible fetal diagnosis—lest they otherwise lose access to a previability abortion. Those patients' loss of their right to speak openly with their physicians or other medical care providers restricts and interferes with their right to abortion.

132. For all these patients, the Reason Ban Scheme operates as an outright ban on, or otherwise restricts and interferes with, their fundamental right to abortion.

B. The Two-Trip Scheme Denies, Restricts, and Interferes with Arizonans' Right to Abortion

133. The Two-Trip Scheme denies, restricts, and interferes with the fundamental right to abortion by requiring multiple unnecessary visits to a health center, which can extend over

bans#:~:text="Access%20to%20reproductive%20services%2C%20including,endangers%20the%20health%20of%20women.

several days if not weeks. These forced delays cause physical, emotional, and financial harm, and sometimes preclude patients from exercising their right to abortion altogether.

134. The Two-Trip Scheme also infringes on the right to abortion by forcing patients to receive biased, stigmatizing, often outdated and/or medically incorrect information that is not relevant to their medical care or their circumstances. This causes emotional harm to patients, serves no purpose other than to impose shame and stigma, and interferes with patients' autonomous decision making.

135. Further, by requiring that all patients without acceptable documentation of blood type receive Rh testing, even where such testing is medically unnecessary based on a patient's pregnancy gestation and medical history, the Two-Trip Scheme, in practice, forces many patients to wait at least a day for their testing to be completed, thereby making it all but impossible to schedule their abortion until at least 24 hours after the patient's first required visit. *See* A.A.C. R9-10-1509(A)(3)(b) (requiring abortion clinics to test for Rh type "before the patient's abortion is performed" "unless the patient provides written documentation of blood type acceptable to the physician"); A.R.S. § 36-449.03(D)(3) (same).

1. Forced Delays

136. The Two-Trip Scheme requires, among other things, that patients seeking abortion care complete an in-person consultation with a licensed physician, undergo Rh testing (absent acceptable documentation of blood type), and receive an ultrasound at least 24 hours before receiving an abortion. A.R.S. § 36-449.03(D)(3); A.R.S. § 36-2153; A.R.S. § 36-2158(A); A.R.S. § 36-2156(A)(1); A.A.C. R9-10-1509(A)(3)(b), (A)(4), (E).

137. In effect, these requirements force patients seeking abortion care to make multiple trips to their healthcare provider to obtain an abortion, regardless of that patient's distance from

the provider, reasons for seeking an abortion, medical circumstances, how certain they are, or how advanced their pregnancy is.

138. There is no medical justification for singling out abortion and overriding a patient's ability to determine, in conjunction with their provider, what information is necessary to receive *in person* (as opposed to over the phone or videoconference) prior to the abortion, when that information should be provided, and whether or when any pre-abortion tests should be performed.

139. Forcing patients to make multiple, unnecessary visits to an abortion provider doubles the amount of time a person needs to take off work or school to obtain abortion care (and doubles the loss of income or risk of losing their job if they have no access to paid sick leave[44]); doubles the time and expense necessary to arrange transportation to and from their healthcare provider, as well as lodging if the patient is traveling a long distance; and doubles the time and expense necessary to arrange childcare. *See supra* §§ II.A, II.F (most abortion patients already face structural barriers to accessing healthcare, have low incomes, and are already parents).

140. Having to arrange, pay for, and make multiple visits also makes it more difficult for an individual to keep their abortion decision confidential from others in their lives, which jeopardizes the safety of those who risk retaliation or violence if their decision is discovered. *See supra* ¶¶ 5, 103.

[44] Arizona employees can accrue up to 24 or 40 hours of paid sick time per year, depending on the size of their employers. A.R.S. § 23-372. Workers without "employee" status have no protected sick time available to them.

141. Moreover, while even a 24-hour mandatory delay for all abortion patients is not legally or medically justifiable, in practice, the Two-Trip Scheme rarely results in only the 24-hour delay required by law.

142. For most patients, it can be difficult to schedule an appointment with a physician on two consecutive days, as appointments are dependent on clinic schedules and physician availability. Additionally, if a patient cannot return on the next available appointment date, for example because they cannot get time off from their job on that day, they will in practice be forced to wait even longer.

143. The Two-Trip Scheme's Rh testing requirement also, in practice, can function as a forced delay that can last more than one day. Major medical organizations agree that Rh testing is not medically necessary prior to 12 weeks LMP.[45] Nonetheless, Arizona mandates Rh testing for all patients without acceptable documentation of blood type, which requires an unnecessary blood draw and lab tests. A.R.S. § 36-449.03(D)(3)(c), (G)(5); A.A.C. R9-10-1509(A)(3)(b), (B). It also mandates that patients undergo Rh testing *before* an abortion, notwithstanding that any treatment a patient may need based on their testing results is effective if given within 72 hours of an abortion—a fact Arizona law itself acknowledges. *See* A.R.S. § 36-449.03(G)(5) (requiring that physicians ensure Rhogam will be available to patients for whom it is indicated within 72 hours after abortion procedure); A.A.C. R9-10-1509(B)(2) (requiring that clinics

[45] Nat'l Abortion Fed'n, *2024 Clinical Policy Guidelines* 12-13 (2024), https://prochoice.org/wp-content/uploads/2024-CPGs-FINAL-1.pdf; ACOG, *ACOG Clinical Practice Update: Rh D Immune Globulin Administration After Abortion or Pregnancy Loss at Less Than 12 Weeks of Gestation*, 144 Obstetrics & Gynecology e140-e143 (Dec. 1, 2024); Sarah Horvath et al., *Society of Family Planning Committee Consensus on Rh Testing in Early Pregnancy*, 114 Contraception P1-5 (Oct. 2022), https://www.contraceptionjournal.org/article/S0010-7824(22)00197-4/fulltext; World Health Organization, *Abortion Care Guideline* 44-45 (2022), https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf.

ensure patients for whom it is indicated are offered Rhogam within 72 hours after abortion procedure).

144. According to ADHS, which conducts laboratory inspections for federal compliance, an Arizona abortion provider cannot comply with Arizona law by providing Rh testing to patients in-house unless the provider becomes certified as a high-complexity lab under onerous federal requirements. Therefore, to test Rh type, a provider must *either* draw the patient's blood at the clinic and send it to an external lab for testing *or* send patients to an external lab to determine the patient's Rh type before their abortion and then have the patient return. External labs take at least one full day but sometimes longer to process patients' lab results.

145. For those traveling from outside the area where the provider is located—in practice, most patients not based in Phoenix or Tucson—paying for round-trip transportation, lodging, childcare, and getting extended time off work can be difficult to do multiple times in a short time period.

146. Patients are frequently forced to delay abortion care in order to amass the financial resources needed to cover transportation, childcare, and/or accommodation costs associated with attending a second appointment. *See supra* ¶ 101.

147. The cost of an abortion typically increases as pregnancy progresses and the procedure becomes more complex. As a result, unnecessary delays may lead to higher total costs, which in turn could lead to further delays as patients struggle to save additional money to cover their care. *See supra*.

148. Even patients local to the clinic may not be able to get time off and arrange childcare and/or transportation twice within 48 hours, or even within the same week.

149. For people seeking a medication abortion, this delay may push them past the point in pregnancy where medication abortion is available; the forced delay will preclude those

patients from obtaining their preferred method of abortion altogether. Because there are even fewer Arizona physicians providing procedural as opposed to medication abortions, it becomes even harder for these patients to locate and obtain an abortion provider. Moreover, when those patients are forced to have a procedural abortion instead due to the Two-Trip Scheme, this can increase wait times and make it more difficult to obtain a procedural abortion.

150. Being prevented from obtaining a wanted abortion and forced to remain pregnant longer can have serious and long-term impacts on a person's health, causing them to face new, pregnancy-related complications or the exacerbation of underlying health conditions.[46]

151. But for each of these laws, Plaintiffs and Plaintiffs' members could provide abortion care for eligible patients without requiring multiple in-person visits and therefore without any medically unnecessary, and harmful, delay.

152. Delays, additional travel distances, and additional trips also hinder a patient's ability to keep their abortion confidential, which is particularly important for survivors of intimate-partner violence and people who have become pregnant as a result of rape or incest. *See supra* ¶¶ 5, 103.

153. Moreover, for patients who are pregnant as a result of rape or incest, being forced to remain pregnant for longer—against their will—because of forced, state-mandated delays only compounds their trauma and threatens their health and well-being.

154. For some patients, the state-imposed barriers to obtaining care will be insurmountable, and those unable to obtain the necessary resources will be prevented from accessing abortion care altogether.

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[46] Lisa H. Harris, *Navigating Loss of Abortion Services – A Large Academic Medical Center Prepares for the Overturn of Roe v. Wade*, 386 New Eng. J. Med. 2061, 2063 (2022), https://www.nejm.org/doi/full/10.1056/NEJMp2206246; Raymond & Grimes, *supra* note 17, at 215–19.

155. In no other area of medicine does Arizona law impose medically baseless delays on patients seeking medical care—in practice, forcing patients to wait days if not weeks to obtain medical care—regardless of their medical circumstances and decisional certainty.

2. Biased Counseling

156. As noted above, Arizona already requires clinicians to obtain informed consent before providing medical treatment, according to their medical judgment. *See supra* ¶ 63.

157. Plaintiff Physicians Drs. Isaacson and Richardson require all clinicians providing in their clinics to obtain informed consent from their patients, consistent with their legal and ethical obligations.

158. However, the Two-Trip Scheme requires that, except in medical emergencies, specific state-mandated information be provided "orally and in person" to every abortion patient at least 24 hours prior to the procedure, regardless of the patient's individual circumstances. A.R.S. § 36-2153(A).[47]

159. In addition to the forced delays, the Two-Trip Scheme's biased counseling requirement, A.R.S. § 36-2153, interferes with and restricts the right to abortion in multiple ways.

160. First, A.R.S. § 36-2153 overrides both physician judgment and patient autonomy by forcing every abortion patient to make a separate visit to their abortion provider to receive

[47] A.R.S. § 36-2153(A)(1) requires that a physician or referring physician provide certain information to a patient "orally and in person." There is no medical reason this counseling must be provided by a physician. The state-mandated counseling could be performed—and prior to 2011, was regularly performed—by other qualified clinicians, such as advanced practice clinicians like nurse practitioners and physician assistants. By mandating that the information in section (A)(1) be delivered by a physician, in practice the information in (A)(2) is also delivered by the physician. These mandatory consultations consume significant amounts of physician time that could otherwise be used to provide abortion care, or other health-care services to patients, and to provide that care more promptly.

certain information in person, as if they are not capable of determining when, if ever, an in-person visit is necessary to receive the information. In no other area of medicine does Arizona law impose a blanket in-person informed consent requirement.

161. Second, A.R.S. § 36-2153 requires a physician to provide every abortion patient with certain information even when it is not relevant to the patient's decision-making process, and even when it may be misleading, stigmatizing, or harmful. This one-size-fits-all approach contradicts the ethical principle that informed consent be tailored to the needs and circumstances of each patient.

162. For example, A.R.S. § 36-2153 requires a physician to describe the "probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed." A description of embryonic or fetal development adds nothing to the process of informing patients about the risks and benefits of abortion. Further, the requirement's language ("unborn child") is value-laden, not medical. And only pregnant people obtaining an abortion—not those continuing their pregnancy or seeking prenatal care—must be given information about embryonic or fetal development, demonstrating that this requirement is aimed to convey the State's disapproval of patients' decision to have an abortion.

163. A.R.S. § 36-2153 also requires physicians to refer patients to a state website[48] that contains biased and inaccurate information about abortion, including inaccurate information about medication abortion. *See supra* ¶ 24(d).

164. A.R.S. § 36-2153 further requires a physician to refer all patients to a state-created pamphlet containing inaccurate and biased information about abortion. For example, the website and pamphlet both state that patients obtaining a medication abortion will receive mifepristone

[48] ADHS, *A Woman's Right to Know Act – Home*, *supra* note 5.

and methotrexate to initiate the abortion, with misoprostol given only in certain cases and at a follow up appointment up to several weeks later.[49] This is not the standard of care for medication abortion and has not been since 2000.[50] It also does not reflect the physician Plaintiffs' practices.

165. Additionally, the pamphlet states that for some women, "the feelings she may experience after the procedure . . . may be more difficult to handle" without support from a professional counselor.[51] This claim is not supported by clinical evidence and has been widely debunked.[52]

166. The pamphlet then refers patients to a "resource directory" of "pregnancy-resource centers" that features crisis pregnancy centers ("CPCs").[53] These CPCs have a clear mission: to discourage pregnant people from exercising their protected right to abortion. Their websites are replete with inaccurate, stigmatizing, and inflammatory statements, including:

a. "We've all seen the ultrasound images of tiny fingers and fingerprints, and videos of a preborn baby's heartbeat, eyelashes, hiccups, and squirms in the womb. We all know the truth. Pro-abortionists like to call it a fetus because it

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[49] ADHS, *A Women's Right to Know*, https://www.azdhs.gov/documents/prevention/womens-childrens-health/informed-consent/a-womans-right-to-know.pdf (last visited May 14, 2025). ADHS, *A Women's Right to Know*, https://www.azdhs.gov/documents/prevention/womens-childrens-health/informed-consent/a-womans-right-to-know.pdf (last visited May 14, 2025).

[50] ACOG Medication Abortion Practice Bulletin, *supra* note 36 ("The medication abortion regimen supported by major medical organizations nationally and internationally includes two medications, mifepristone and misoprostol.").

[51] ADHS, *A Women's Right to Know*, *supra* note 49.

[52] M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74(2) JAMA Psychiatry 169–78 (2017).

[53] ADHS, *A Women's Right to Know*, *supra* note 49.

sounds like a neutralized bit of matter, but a fetus is just the Latin word for a baby."[54]

b. "Young people today are singing about killing babies, trampling their graves, and even eating them. If this behavior bothers you at all, then your feelings likely point to a deeper knowledge of the truth: abortion ends an innocent life."[55]

c. "Abortion is a sin unless it is medically necessary in order to save the life of the mother. But even when a medical abortion appears needed to preserve a mother's life, the Christian will always proceed with the intent to preserve all human life whenever possible."[56]

d. "Some research suggests links between abortion and the following conditions:" "Breast cancer"; "Pre-term birth in subsequent pregnancies"; "Increased rates of mental health issues like PTSD and depression."[57]

e. Multiple CPC websites advertise so-called "abortion reversal",[58] an

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[54] Choices Pregnancy Ctrs., *The Disturbing Truth Behind "Shout Your Abortion"* , https://choicesaz.com/the-disturbing-truth-behind-shout-your-abortion/ (last visited May 14, 2025); *but see* Mirriam-Webster Dictionary, *Fetus*, https://www.merriam-webster.com/dictionary/fetus (last visited May 14, 2025) (defining a "fetus" as "an unborn or unhatched vertebrate especially after attaining the basic structural plan of its kind").

[55] *The Disturbing Truth, supra* note 54.

[56] Alpha Pregnancy Resource Ctr., *What We Believe: Our position on abortion*, https://www.alphacenterphx.org/what-we-believe (last visited May 14, 2025).

[57] Choices Pregnancy Ctrs., *What are the After Effects of Abortion?*, https://choicesaz.com/what-are-the-after-effects-of-abortion/ (last visited May 14, 2025); *contra* Biggs et al., *supra* note 52, at 169.

[58] *See*, e.g., Aid to Women Ctr., *Abortion Reversal*, https://aidtowomencenter.org/abortion-reversal (last visited May 14, 2025); Phoenix Women's Clincs, *Abortion Pill Reversal*, https://phoenixwomensclinic.com/phoenix/abortion/abortion-pill-reversal/ (last visited May 14, 2025); Choices Pregnancy Ctrs., Abortion Pill Reversal, https://choicesaz.com/get-care/abortion-pill-reversal/ (last visited May 14, 2025).

experimental, and potentially dangerous medical treatment that has been widely disproven.[59]

167. By forcing a physician to refer patients to state-sponsored websites and materials containing inaccurate and misleading information, and promoting anti-abortion views, regardless of whether the patient has expressed interest in such materials, the State overrides physicians' clinical judgment, using the physician as a conduit for the State's clear message of disapproval to a patient under the guise of informed consent.

168. Distorting the informed consent process in this manner adversely affects Plaintiffs' patients. A key purpose of informed consent is to provide a patient considering a course of medical treatment with clear, medically accurate information so that she can make a considered decision whether to proceed with the treatment. Patients rely on their medical providers to present them with truthful, relevant facts in a clear manner to facilitate thoughtful decision making. Forcing physicians to make irrelevant and biased statements during the informed consent process risks confusing patients and damaging the physician-patient relationship.

169. Requiring physicians to provide and direct patients to biased information intended to discourage abortion forces physicians to shame their patients for their healthcare decisions. This can place physicians in the position of having to violate the fundamental medical ethics principles of benevolence and respecting patient autonomy, and can harm patients by causing

[59] ACOG has determined that "no evidence" supports the efficacy of so-called medication abortion "reversal," and that interrupting the two-drug medication abortion regimen may be associated with medical risk. ACOG Medication Abortion Practice Bulletin, *supra* note 36. The AMA not only opposes mandated disclosures about this practice, but also has sued North Dakota over a medication abortion "reversal" speech mandate on the basis that the disclosure was misleading and untruthful. *See Am. Med. Ass'n v. Stenhjem*, 412 F. Supp. 3d 1134, (D.N.D. 2019), *dismissed pursuant to stipulation*, *Am. Med. Ass'n v. Wrigley*, No. 1:19-CV-125, 2023 WL 8866596, at *1 (D.N.D. Oct. 18, 2023). !

shame, psychological harm, and erosion of the trust necessary for facilitating a healthy doctor-patient relationship.

170. Accordingly, by requiring Plaintiffs to force medically inaccurate and biased and potentially harmful messages on their patients, as well as direct their patients to websites and pamphlets containing the same, as a condition of receiving care, the Two-Trip Scheme violates fundamental principles of informed consent and medical ethics, restricting and interfering with patient autonomy to make the best medical decisions for themselves, in consultation with their provider.

C. The Telemedicine Ban Scheme Denies, Restricts, and Interferes with Arizonans' Right to Abortion

171. The Telemedicine Ban Scheme imposes medically unnecessary limits on, and restricts access to, medication abortion. Its components work alone and in conjunction to require extra, unnecessary travel and to deny pregnant individuals access to a healthcare delivery tool that is not only available to other Arizonans but also affirmatively promoted by the State.

172. By carving out a single, medically unsupported exception to telemedicine for abortion, the State denies people seeking abortion care access to a service that is available and widely recognized to benefit other Arizonans.

173. Further, by precluding pregnant Arizonans from accessing time-sensitive abortion care through telemedicine, the State forces patients to make at least one trip to a health center, which could entail traveling hundreds of miles, to pick up medications for use at home.

174. Mandating that patients travel to obtain in-person counseling and/or abortion medication delays access to care. This delay, in turn, exposes patients to unnecessary medical risks because it forces them to remain pregnant longer and because, although abortion is very

safe, its risks increase as pregnancy progresses. It also compels patients to take more time off from work or school and to incur costs associated with transportation, lodging, and childcare.

175. For example, a March 2025 study concluded that, compared to patients who had to attend an in-person appointment with an ultrasound, patients who were able to access medication abortion via telemedicine and the receipt of medications in the mail faced fewer structural challenges (such as travel and cost) accessing abortion, felt less forced to wait after making their decision, and reported increased autonomy in the abortion decision.[60]

176. For some patients, including those for whom a medication abortion is medically indicated or highly preferred, the delay and travel imposed by the Telemedicine Ban Scheme denies them the abortion method of their choice or precludes them from accessing abortion altogether.

177. Denying Arizonans the right to telemedicine abortion care, which has been proven safe and effective and which providers are willing and able to provide, deprives Arizonans of the opportunity to consider and avail themselves of that medical care.

D. The Two-Trip, Reason Ban, and Telemedicine Ban Schemes Do Not Serve a Compelling State Interest

178. Under article II, section 8.1 of the Arizona Constitution, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . denies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means."

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[60] M. Antonia Biggs et al., *Psychosocial Burden When Accessing Medication Abortion When Using No-Test Telehealth Care Compared to In-Person Care with Ultrasound*, Contraception (Mar. 27, 2025), https://www.contraceptionjournal.org/article/S0010-7824(25)00085-X/fulltext.

179. As described *supra*, the Schemes deny, restrict, and interfere with the fundamental right to abortion and are therefore presumptively unconstitutional.

180. To be justified by a compelling state interest under the Amendment, the Schemes must meet two requirements: (1) they must be "enacted or adopted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," *and* (2) they must "not infringe on that individual's autonomous decision making." Ariz. Const. art. II, § 8.1(B)(1)(a)–(b). A law cannot survive constitutional scrutiny under the Amendment if it fails *either* part of this test.

181. The Two-Trip, Reason Ban, and Telemedicine Ban Schemes each fail both parts of this test.

1. The Schemes Infringe on Arizonans' Autonomous Decision Making.

182. The Reason Ban, Two-Trip, and Telemedicine Ban Schemes each violate fundamental clinical principles of informed consent, decisional autonomy, and bodily integrity, *see supra* ¶¶ 129–31, 149–55, 160–70, 176–77, and thus they "infringe on [ ] individual[s'] autonomous decision making." Ariz. Const. art. II, § 8.1(B)(1)(b).

183. *Reason Ban Scheme*. The Reason Ban Scheme prohibits physicians from providing certain abortions where the State disapproves of a patient's reason. Banning or restricting pre-viability abortion based on a patient's reason for seeking abortion care by definition infringes on an individual's autonomous decision making and is per se unconstitutional. The Reason Ban Scheme also interferes with the physician-plaintiff relationship.

184. *Two-Trip Scheme.* The Two-Trip Scheme infringes on autonomous decision making by demeaning patients' decision making capability and embracing unwarranted stereotypes that women and pregnant people cannot make decisions and must be protected from

their own actions, as well as creating unnecessary obstacles to Arizonans' ability to effectuate their constitutionally protected decision to have an abortion.

185. The Two-Trip Scheme's mandatory 24-hour delay, which, as noted *supra*, is much longer in practice, singles out and subjects abortion patients to a forced "time out" on the assumption that they are not capable of making autonomous decisions without it.

186. To the contrary, clinical studies have shown that pregnant patients are capable of understanding the consequences of obtaining an abortion and making the decision to do so without any additional waiting period, and that state-mandated delays hinder rather than enhance decisional autonomy.[61] For some patients, the delays and unnecessary additional expenses and logistical hurdles caused by the forced delay robs them of their decisional autonomy completely by entirely blocking them from accessing abortion care in Arizona.

187. The Two-Trip Scheme's one-size-fits-all requirement that providers dispense the State's version of information to patients also thwarts the true goals of informed consent, which is inherently individualized, and undermines autonomous decision making. Forcing providers to tell patients information that is unnecessary, irrelevant, inaccurate, and/or stigmatizing—all for the purpose of dissuading people from choosing to have an abortion—damages patient-provider trust and takes time and attention from information targeted at the individual patient's needs.

188. The Two-Trip Scheme's state-mandated counseling requirements are also at odds with accepted clinical standards of practice, which require an unbiased, individualized informed

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[61] *See, e.g.*, Iris Jovel et al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, 137(4) Obstetrics & Gynecology 597 (2021) (finding no increase in decisional certainty in patients seeking care in states with mandatory waiting periods as compared to their counterparts in states without such barriers); *see also* Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95(3) Contraception 269 (2017); Diana Greene Foster, *Attitudes and Decision Making Among Women Seeking Abortions at One US Clinic*, 44(2) Perspectives on Sexual and Reproductive Health 117 (2012).

consent process. The non-medical, inaccurate, irrelevant, and biased information that the Two-Trip Scheme requires providers to convey to patients, at least 24 hours before receiving abortion care, thwarts these principles. Using the physician-patient relationship to convey the State's disapproval of a patient's healthcare choices is also the antithesis of informed consent, as is forcing patients to consume uniform information not tailored to their individual circumstances.

189. Further, the Two-Trip Scheme forces providers to refer patients to state-created materials that contain extensive fetal imagery and are weighted toward encouraging continuing a pregnancy. These materials contain numerous inaccuracies about abortion procedures, the safety of abortion care, and fetal development. They are designed to induce shame and persuade people to change their mind about having an abortion regardless of their personal circumstances—the opposite of encouraging autonomous decision making.

190. The Two-Trip Scheme's biased counseling provisions also interfere with patients' decisional autonomy by compelling people who are pregnant as a result of rape or incest to listen to a description of fetal development, as well as by requiring patients experiencing the devastating loss of a wanted pregnancy to receive information about alternatives that are not available to them.

191. *Telemedicine Ban Scheme.* By prohibiting physicians from expanding access to abortion care via telemedicine, particularly for patients in Arizona's many rural counties, the Telemedicine Ban Scheme similarly imposes unnecessary obstacles in the path of Arizonans trying to effectuate their autonomous decision to have an abortion.

192. The Telemedicine Ban Scheme interferes with patients' autonomous decision making by denying them their chosen method of receiving abortion care—by telehealth.

193. Patients are instead forced to travel potentially long distances, take time off work, arrange for childcare, and experience delays, medical tests, and physical examinations in order to follow through with their decision.

194. As a result, some patients for whom medication abortion is either medically indicated or preferred due to its unique benefits, such as privacy and control, are precluded from obtaining it. This is a blatant violation of their autonomous decision to obtain a medication abortion.

195. Denying patients access to medication abortion via telemedicine can also thwart patients' autonomous decision making by exacerbating dangerous circumstances, such as risking the privacy of a patient experiencing intimate-partner violence, to the extent that the patient cannot safely carry out their decision to have an abortion.

2. The Challenged Schemes Do Not Improve or Maintain the Health of the Person Seeking Abortion Care

196. Even if the Reason Ban, Two-Trip, or Telemedicine Ban Schemes *could* satisfy the decisional autonomy prong—which they cannot—they would nevertheless be unconstitutional because they do not "improv[e] or maintain[] the health of an individual seeking abortion care consistent with accepted clinical standards of practice and evidence-based medicine." Ariz. Const. art. II, § 8.1(B)(1)(a).

197. *Reason Ban Scheme.* The Reason Ban Scheme does not maintain or advance patient health. Rather, by interfering with autonomous decision making and banning pre-viability abortion care for certain patients, it undermines patient health.

198. Preventing a patient from accessing an abortion due to that patient's reason for seeking care does not improve the patient's health or safety. To the contrary, it undermines that

patient's health by forcing them to remain pregnant against their will and exposing them to the physical risks of pregnancy and the mental health risks associated with denied abortion care.[62]

199. Further, forcing patients to conceal their medical history and reasons for seeking abortion care from their medical providers for fear of denial of care is antithetical to accepted clinical standards and accordingly cannot improve or maintain the patients' health.

200. Delays caused by forcing patients to travel out of state to obtain care that clinicians in Arizona are willing and able to provide but for the Reason Ban Scheme is affirmatively harmful. The specter of this interferes with the physician-patient relationship, even for patients who are still able to obtain care in Arizona. *See supra* at ¶¶ 129–31.

201. *Two-Trip Scheme.* The Two-Trip Scheme violates fundamental clinical principles of informed consent, decisional autonomy, and bodily integrity. *See supra* ¶¶ 149–55, 160–70. Far from improving or maintaining the health of individuals seeking abortion care, this *undermines* their health and thus is not "consistent with accepted clinical standards of practice and evidence-based medicine." Ariz. Const. art. II, § 8.1(B)(1)(a); *see also supra* ¶¶ 63–73.

202. For example, there is no medical justification for requiring *all* patients, regardless of their circumstances or medical histories, to have an ultrasound 24 hours prior to receiving an abortion; receive information and counseling in person, at least 24 hours before the procedure; or undergo Rh testing that can delay care up to 24 hours. To the contrary, these blanket requirements introduce delays that, as discussed *supra*, undermine patients' health.

203. Moreover, forcing abortion patients to make multiple trips to their healthcare provider to obtain abortion care, sometimes requiring lengthy travel and/or overnight stays,

[62] *See* Diana Greene Foster, *The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having—or Being Denied—an Abortion*, Scribner chs. 4, 5 (2020) (comparing the physical and mental health effects of abortion with continued pregnancy and childbirth).

jeopardizes patients' ability to keep their healthcare decisions confidential. This exposes patients who are experiencing intimate partner violence or are otherwise at risk of abuse to increased risk of harm if their decision is discovered. It can also take a substantial toll on patients' emotional and psychological health or even prevent them from obtaining abortion care altogether.

204. The sole effect of the mandatory delay is to force patients to remain pregnant longer than necessary, against their will.

205. Mainstream medical consensus dictates that the best evidence-based medical practice is to provide patients with timely abortion care without any unnecessary delays, and that abortion restrictions like the Two-Trip Scheme do not improve patient health. For example, ACOG and the Society of Family Planning ("SFP") firmly oppose these laws. In a Committee Statement, also endorsed by SFP, ACOG has "called for the cease of and repeal of all legislation, policy, and executive actions that ban abortion, create barriers to abortion access, or interfere with the patient–health care professional relationship and the practice of medicine, including," *inter alia*, "[m]andatory . . . ultrasonography and waiting periods before obtaining abortion care" and "[m]andatory counseling on abortion risks that are not based on current understandings of published evidence."[63]

206. *Telemedicine Ban Scheme.* Prohibiting the provision of abortion care through telemedicine and the mailing of abortion medications likewise does not advance patient health in accordance with widely accepted and evidence-based standards of care.

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[63] ACOG, *Committee Statement No. 16: Increasing Access to Abortion* (Feb. 2025), https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion; *see also* National Academies Safety Report, *supra* note 11, at 163 (finding that "abortion-specific regulations on the site and nature of care, provider type, provider training, and public funding diminish . . . quality care" by "delay[ing] care unnecessarily from a clinical standpoint," "prohibit[ing] qualified clinicians . . . from performing abortion," and "mandat[ing] clinically unnecessary services" such as "preabortion ultrasound[s]" and "in-person counseling visit[s].").

207. Telemedicine has been used to safely provide medication abortion for more than a decade and has been deemed to be as safe as the provision of medication abortion in person at a clinic. According to the National Academies of Sciences, Engineering, and Medicine, "[t]here is no evidence that the dispensing or taking of mifepristone tablets requires the physical presence of a clinician . . . to ensure safety or quality. The effects of mifepristone occur after women leave the clinic, and extensive research shows that serious complications are rare."[64]

208. Similarly, ACOG has concluded that "[m]edication abortion can be provided safely and effectively by telemedicine with a high level of patient satisfaction" and that such telemedicine "improves access to early abortion care, particularly in areas that lack a health care practitioner."[65]

209. SMFM too has affirmed that "[t]elemedicine access for medication abortion provides successful, safe outcomes when compared with in-person visits."[66]

210. Because telemedicine bans for abortion delay access to care, ACOG, SFP, the AMA, and other major medical organizations have taken a strong position against them. As ACOG and the AMA stated in an amicus brief filed in the Supreme Court just last year, they "are aware of no medical basis to exclude those in need of reproductive care from accessing it through telemedicine," as their "patients would [not] be better served by returning to an era that mandated repeated, wholly unnecessary office visits for the prescription and use of an

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[64] National Academies Safety Report, *supra* note 11, at 79.

[65] ACOG Medication Abortion Practice Bulletin, *supra* note 36.

[66] SMFM, *Special Statement: Telemedicine in Obstetrics—Quality and Safety Considerations* at B9, Table 1 (Mar. 2023), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2902261-X.

exceedingly safe medication."[67] Indeed, "[f]or prescription of mifepristone for use in medication abortion . . . telehealth protocols offer the same protections as in-person dispensing and provide an equivalent level of care."[68]

211. In addition, Arizona's ban on mailing abortion medications runs counter to the Food and Drug Administration's regulations that expressly permit the mailing of mifepristone. As the AMA, ACOG, and other leading medical associations have stated, "[m]ifepristone has been available by mail since" 2021, during which time their "members have observed *no change whatsoever* in the incidence of adverse events from mifepristone."[69]

E. The Challenged Laws Violate the Prohibition on Penalizing Providers for Assisting People in Accessing Abortion

212. In addition to infringing Arizonans' right to abortion, the Reason Ban, Two-Trip, and Telemedicine Ban Schemes are unconstitutional for the independent reason that they penalize abortion providers for assisting people in exercising that fundamental right. *See* Ariz. Const. art. II, § 8.1(A)(3).

213. For example, by imposing a maze of overlapping, inconsistent, and seemingly contradictory requirements, the Reason Ban Scheme exposes physicians and other healthcare providers to felony penalties punishable by prison time, professional penalties that include suspension or loss of licensure, and extensive civil penalties. *See supra* ¶¶ 14–23.

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[67] Br. of American Coll. of Obstetricians & Gynecologists et al., as Amici Curiae Supporting Petitioners at 24, *FDA v. All. for Hippocratic Med*., 602 U.S. 367 (2024) (Nos. 23-235 & 23-236).

[68] *Id*. at 23.

[69] *Id.* at 25; *see also* FDA Ctr. For Drug Eval. & Rsch., *Medical Review, Application No. 020687Orig1s020,* 47 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf (rates of clinically significant adverse events arising from medication abortion are exceedingly rare, generally far below 0.1%).

214. In addition to imposing liability on abortion providers, the Reason Ban Scheme creates liability for *any* Arizona medical provider or counselor who has knowledge of a violation of the Reason Ban and does not report it to law enforcement. A.R.S. § 13-3603.02(E); *see also supra* ¶ 22.

215. The Two-Trip Scheme prevents physicians who provide abortions from practicing evidence-based medicine and forces them to violate fundamental principles of medical ethics or face license suspension or revocation, in addition to other civil penalties. *See* A.R.S. § 36-2153(J), (L); A.R.S. § 36-2156(B), (D).

216. The Telemedicine Ban Scheme prevents providers from offering timely medication abortion care consistent with best clinical practices and subjects those who violate it to license suspension or revocation. A.R.S. § 36-3604.

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217. In addition to the penalties listed above, the Arizona Medical Board is separately authorized to initiate independent investigations, separate from any criminal process, to determine if a physician has engaged in unprofessional conduct, which includes "violating any federal or state laws, rules or regulations applicable to the practice of medicine" and "committing a felony," A.R.S. §§ 32-1401(27), 32-1403(A)(2), 32-1451(A), and to discipline licensed physicians based on their findings, which can include suspension or revocation of a medical license, public censure, and civil penalties of at least $1,000 and up to $10,000 for each violation found, A.R.S. §§ 32-1403(A)(5), 32-1403.01(A), 32-1451(D)–(E), (I), and (K).

218. The Director of ADHS is independently authorized to "assess a civil penalty against a person who violates" any provision of A.R.S. Chapter 36, or any rule adopted pursuant to A.R.S. Chapter 36 up to $1,000 per violation, per day. A.R.S. § 36-431.01. In addition, a

separate violation may be assessed "for each resident or patient who the department determines was impacted by the violation." *Id*.

219. The Director of ADHS is also independently authorized to suspend or revoke the license of any abortion clinic that fails to "adher[e] to" "any [ ] law or rule concerning abortion." *See* A.R.S. § 36-449.02.

220. County attorneys are authorized to "conduct all prosecutions for public offenses," A.R.S. § 11-532(A)(1), subject to the Attorney General's supervisory authority to enforce the laws of Arizona. *See* A.R.S. § 41-193(A)(4) (the attorney general "shall . . . [e]xercise supervisory powers over county attorneys of the several counties"); *Crosby-Garbotz v. Fell in and for Cnty. of Pima*, 246 Ariz. 54, 60 ¶ 24 (2019) (holding the same).

221. Thus, the Challenged Laws penalize individuals and entities for aiding or assisting a pregnant individual in exercising their right to abortion, and they are unconstitutional.

CLAIMS FOR RELIEF

COUNT I

(Declaratory Judgment – Fundamental Right to Abortion)

222. Plaintiffs incorporate paragraphs 1 through 221 as if set forth herein.

223. Under article II, section 8.1 of the Arizona Constitution, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . denies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means." Ariz. Const. art. II, § 8.1(A)(1).

224. As set forth *supra* in Sections III.A through III.C, the Challenged Laws deny, restrict, and/or interfere with the fundamental right to abortion.

225. To be justified by a compelling state interest under the Amendment, the Challenged Laws must meet two requirements: (1) they must be "enacted or adopted for the

limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," and (2) they must "not infringe on that individual's autonomous decision making." Ariz. Const. art. II, § 8.1(B)(1)(a)–(b).

226. As set forth *supra* in Sections III.D, the Challenged Laws cannot satisfy both prongs, and thus they are not justified by a compelling state interest.

227. The Challenged Laws deprive Plaintiffs' patients of their fundamental right to abortion under the Arizona Constitution, causing them to suffer significant constitutional, physical, psychological, and other harms.

228. There is no adequate remedy at law to address these harms.

229. For all these reasons, Plaintiffs' patients' rights, status, and other legal relations are directly affected by the Challenged Laws, and Plaintiffs' patients are thus entitled to a "declaration of rights, status or other legal relations thereunder." *See* A.R.S. § 12-1832.

COUNT II

(Declaratory Judgment—Prohibition on Penalizing an Individual for Assisting a Pregnant Individual in Exercising Their Right to Abortion)

230. Plaintiffs incorporate paragraphs 1 through 229 as if set forth herein.

231. Article II, section 8.1 of the Arizona Constitution provides: "[T]he state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . penalizes any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion." Ariz. Const. art. II, § 8.1(A)(3).

232. By prohibiting Plaintiffs from providing certain abortions; requiring them to violate their ethical obligations to force patients to undergo medically unnecessary mandatory delays, physical examinations, and biased counseling; and otherwise compromising their ability

to provide abortion care in accordance with their ethical obligations under threat of severe criminal, civil, and licensing penalties, the Challenged Laws penalize individuals and entities for aiding or assisting a pregnant individual in exercising the individual's right to abortion in direct defiance of the Amendment, causing Plaintiffs' patients to suffer significant constitutional, psychological, and other harms.

233. Plaintiffs have no adequate remedy at law to address these harms.

234. For all these reasons, Plaintiffs' rights, status, and other legal relations are directly affected by the Challenged Laws, and Plaintiffs are thus entitled to a "declaration of rights, status or other legal relations thereunder." A.R.S. § 12-1832.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ask this Court:

A. That the Court issue a declaratory judgment declaring that the Reason Ban Scheme, A.R.S. § 13-3603.02, A.R.S. § 36-2157, A.R.S. § 36-2158(A)(2)(d), and A.R.S. § 36-2161(A)(25); the Two-Trip Scheme, A.R.S. § 36-2153(A), (F), A.R.S. § 36-2158(A), A.R.S. § 36-2156(A), A.R.S. § 36-2162.01, A.R.S. § 36-449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1), and the Telemedicine Ban Scheme, A.R.S. § 36-2153(A), A.R.S. § 36-2156(A), A.R.S. § 36-2158(A), A.R.S. § 36-3604, A.R.S. § 36-2160(B), A.R.S. § 36-449.03(D), A.A.C. R9-10-1501(8), and A.A.C. R9-10-1509(A)-(E), are unconstitutional in violation of article II, section 8.1 of the Arizona Constitution;

B. For a preliminary injunction enjoining Defendant from enforcing the Reason Ban Scheme, Two-Trip Scheme, and Telemedicine Ban Scheme;

C. For a permanent injunction enjoining Defendant from enforcing the Reason Ban Scheme, Two-Trip Scheme, and Telemedicine Ban Scheme;

D. For an order awarding Plaintiffs their attorneys' fees under the private attorney general doctrine or any applicable statute or common law doctrine;

E. For an order awarding Plaintiffs their taxable costs under A.R.S. §§ 12-341 and 12-1840; and

F. For any other relief as may be appropriate.

Dated: May 22, 2025

PERKINS COIE LLP

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Attorneys for Arizona Medical Association

**Application for admission pro hac vice forthcoming*

Verification

I, Paul A. Isaacson, M.D., state as follows:

I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in the foregoing Complaint are true and accurate.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21ST day of May, 2025.

Paul A. Isaacson, M.D.

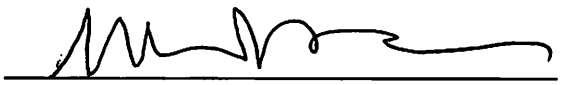
Verification

I, William Richardson, M.D., state as follows:

I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in the foregoing Complaint are true and accurate.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21st day of May, 2025.



William Richardson, M.D.

Verification

I, Nadeem Kazi, state as follows:

I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in the foregoing Complaint are true and accurate.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21 day of MAY, 2025.

Nadeem Kazi, M.D.
President, Arizona Medical Association

EXHIBIT A

STATE OF ARIZONA

Application for Serial Number
Initiative Petition
A.R.S. § 19-111

FOR OFFICE USE ONLY
FILED
SEP 12 2023
ARIZONA SECRETARY OF STATE

The undersigned intends to circulate and file an initiative petition and hereby makes application for the issuance of an official serial number to be printed in the lower right-hand corner of each side of each signature sheet of such petition. Attached hereto is the full title and text, in no less than eight point type, of the measure or constitutional amendment intended to be initiated at the next general election.

☐ **Statutory Measure** ☑ **Constitutional Amendment**

Date of Application	Sept. 12, 2023
Signatures Required	383,923
Deadline for Filing	July 03, 2024
Serial Number Issued	I-05-2024

The Arizona Abortion Access Act amends the Arizona Constitution to establish a fundamental right to abortion that the State (defined by the act to mean the State, an agency of the State, or a political subdivision of the State) may not deny, restrict or interfere with [1] before the point in pregnancy when a health care provider determines that the fetus has a significant likelihood of survival outside the uterus without extraordinary medical measures unless justified by a compelling governmental interest (defined by the act as a law, regulation, policy, or practice enacted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine, and that does not infringe on that individual's autonomous decision-making) that is achieved by the least restrictive means, or [2] after that point in pregnancy if a health care provider determines an abortion is necessary to protect the life or the physical or mental health of the pregnant individual; and under which the State may not penalize individuals or entities for assisting a pregnant individual in exercising their right to abortion.

Dacey Montoya
Name of Applicant

2800 N. Central Ave Ste 1900
Address

Phoenix | AZ | 85004
City | **State** | **Zip**

623-239-2588
Telephone Number

info@arizonaforabortionaccess.org
E-mail Address

Arizona for Abortion Access
Committee Name

101432
Committee ID No.

Candace Lew
Chairperson

Dacey Montoya
Treasurer

2800 N. Central Ave Ste 1900
Committee Address

Phoenix | AZ | 85004
City | **State** | **Zip**

623-239-2588
Committee Telephone Number

info@arizonaforabortionaccess.org
Committee E-mail Address

By submitting this Application for Serial Number and checking all boxes below, I acknowledge the following:

☑ That I have read and understand the accompanying Instructions for Statewide Initiatives, including the Secretary of State's recommended best practices for printing copies of the Statewide Initiative Petition to be circulated.

☑ That at the time of filing, I was provided instructions regarding accurate completion of the electronic Statewide Initiative Petition form.

Applicant Signature

September 11, 2023
Date

Office of the Secretary of State
1700 W. Washington Street
Phoenix, Arizona 85007

Rev. 08/07/2023

OFFICIAL TITLE

A CONSTITUTIONAL AMENDMENT

AMENDING ARTICLE II, CONSTITUTION OF ARIZONA, BY ADDING SECTION 8.1; RELATING TO THE FUNDAMENTAL RIGHT TO ABORTION.

TEXT OF PROPOSED AMENDMENT

Be it enacted by the People of the State of Arizona:

Sec. 1. Short title

This constitutional amendment shall be known as, and may be referred to as, the "Arizona Abortion Access Act".

Sec. 2. Findings and declaration of purpose

The People of the State of Arizona find and declare as follows:

A. Arizonans believe strongly in individual autonomy, which includes the right of each individual to make personal decisions about their own health care without overbearing and unnecessary government interference.

B. When the United States Supreme Court overturned *Roe v. Wade* and deprived Arizonans of their longstanding individual right to abortion, Arizonans' autonomy over their own health care decisions was immediately threatened by efforts to enforce a law first enacted in the 19th Century that made almost all abortions illegal.

C. To protect Arizonans' rights and ensure access to reproductive health care, the Arizona Constitution must be amended to establish a fundamental right to abortion as provided in this act.

D. This act should be liberally construed in furtherance of the fundamental right it establishes.

Sec. 3. Article II, Constitution of Arizona, is amended by adding section 8.1, to read:

8.1. Fundamental right to abortion; definitions

A. EVERY INDIVIDUAL HAS A FUNDAMENTAL RIGHT TO ABORTION, AND THE STATE SHALL NOT ENACT, ADOPT OR ENFORCE ANY LAW, REGULATION, POLICY OR PRACTICE THAT DOES ANY OF THE FOLLOWING:

1. DENIES, RESTRICTS OR INTERFERES WITH THAT RIGHT BEFORE FETAL VIABILITY UNLESS JUSTIFIED BY A COMPELLING STATE INTEREST THAT IS ACHIEVED BY THE LEAST RESTRICTIVE MEANS.

2. DENIES, RESTRICTS OR INTERFERES WITH AN ABORTION AFTER FETAL VIABILITY THAT, IN THE GOOD FAITH JUDGMENT OF A TREATING HEALTH CARE PROFESSIONAL, IS NECESSARY TO PROTECT THE LIFE OR PHYSICAL OR MENTAL HEALTH OF THE PREGNANT INDIVIDUAL.

3. PENALIZES ANY INDIVIDUAL OR ENTITY FOR AIDING OR ASSISTING A PREGNANT INDIVIDUAL IN EXERCISING THE INDIVIDUAL'S RIGHT TO ABORTION AS PROVIDED IN THIS SECTION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "COMPELLING STATE INTEREST" MEANS A LAW, REGULATION, POLICY OR PRACTICE THAT MEETS BOTH OF THE FOLLOWING:

(a) IS ENACTED OR ADOPTED FOR THE LIMITED PURPOSE OF IMPROVING OR MAINTAINING THE HEALTH OF AN INDIVIDUAL SEEKING ABORTION CARE, CONSISTENT WITH ACCEPTED CLINICAL STANDARDS OF PRACTICE AND EVIDENCE-BASED MEDICINE.

(b) DOES NOT INFRINGE ON THAT INDIVIDUAL'S AUTONOMOUS DECISION MAKING.

2. "FETAL VIABILITY" MEANS THE POINT IN PREGNANCY WHEN, IN THE GOOD FAITH JUDGMENT OF A TREATING HEALTH CARE PROFESSIONAL AND BASED ON THE PARTICULAR FACTS OF THE CASE, THERE IS A SIGNIFICANT LIKELIHOOD OF THE FETUS'S SUSTAINED SURVIVAL OUTSIDE THE UTERUS WITHOUT THE APPLICATION OF EXTRAORDINARY MEDICAL MEASURES.

3. "STATE" MEANS THIS STATE, ANY AGENCY OF THIS STATE OR ANY POLITICAL SUBDIVISION OF THIS STATE.

Sec. 4. Severability

If any provision of this measure or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the measure that can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

Sec. 5. Submission to the electorate

The Secretary of State shall submit this measure to the qualified electors of the State of Arizona at the next general election as provided by article IV, part 1, section 1, Arizona Constitution.

Sec. 6. Standing

The People of the State of Arizona desire that this measure, if approved by the voters and thereafter challenged in court, be defended by the State of Arizona. The political action committee that sponsored this measure (or its designee) shall have standing to initiate or intervene in any action or proceeding to enforce defend this measure.

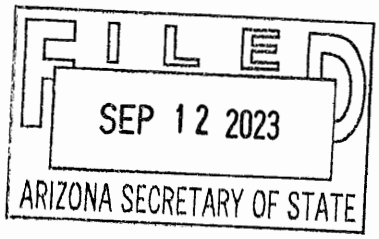


EXHIBIT B

Arizona Revised Statutes Annotated
Title 13. Criminal Code (Refs & Annos)
Chapter 36. Family Offenses (Refs & Annos)

A.R.S. § 13-3603.02

§ 13-3603.02. Abortion; sex and race selection; genetic abnormality; injunctive and civil relief; failure to report; definitions

Currentness

A. Except in a medical emergency, a person who knowingly does any of the following is guilty of a class 6 felony:

1. Performs an abortion knowing that the abortion is sought based on the sex or race of the child or the race of a parent of that child.

2. Performs an abortion knowing that the abortion is sought solely because of a genetic abnormality of the child.

B. A person who knowingly does either of the following is guilty of a class 3 felony:

1. Uses force or the threat of force to intentionally injure or intimidate any person for the purpose of coercing a sex-selection or race-selection abortion or an abortion because of a genetic abnormality of the child.

2. Solicits or accepts monies to finance a sex-selection or race-selection abortion or an abortion because of a genetic abnormality of the child.

C. The attorney general or the county attorney may bring an action in superior court to enjoin the activity described in subsection A or B of this section.

D. The father of the unborn child who is married to the mother at the time she receives a sex-selection or race-selection abortion or an abortion because of a genetic abnormality of the child, or, if the mother has not attained eighteen years of age at the time of the abortion, a maternal grandparent of the unborn child, may bring a civil action on behalf of the unborn child to obtain appropriate relief with respect to a violation of subsection A or B of this section. The court may award reasonable attorney fees as part of the costs in an action brought pursuant to this subsection. For the purposes of this subsection, "appropriate relief" includes monetary damages for all injuries, whether psychological, physical or financial, including loss of companionship and support, resulting from the violation of subsection A or B of this section.

E. A physician, physician's assistant, nurse, counselor or other medical or mental health professional who knowingly does not report known violations of this section to appropriate law enforcement authorities shall be subject to a civil fine of not more than $10,000.

F. A woman on whom a sex-selection or race-selection abortion or an abortion because of a child's genetic abnormality is performed is not subject to criminal prosecution or civil liability for any violation of this section or for a conspiracy to violate this section.

G. For the purposes of this section:

1. “Abortion” has the same meaning prescribed in § 36-2151.

2. “Genetic abnormality”:

(a) Means the presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression.

(b) Does not include a lethal fetal condition. For the purposes of this subdivision, “lethal fetal condition” has the same meaning prescribed in § 36-2158.

3. “Medical emergency” has the same meaning prescribed in § 36-2151.

Credits
Added by Laws 2011, Ch. 9, § 1. Amended by Laws 2021, Ch. 286, § 2.

A. R. S. § 13-3603.02, AZ ST § 13-3603.02
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2157

§ 36-2157. Affidavit

Currentness

A person shall not knowingly perform or induce an abortion before that person completes an affidavit that:

1. States that the person making the affidavit is not aborting the child because of the child's sex or race or because of a genetic abnormality of the child and has no knowledge that the child to be aborted is being aborted because of the child's sex or race or because of a genetic abnormality of the child.

2. Is signed by the person performing or inducing the abortion.

Credits

Added as § 36-2156 by Laws 2011, Ch. 9, § 2. Renumbered as § 36-2157. Amended by Laws 2021, Ch. 286, § 10.

A. R. S. § 36-2157, AZ ST § 36-2157
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

A.R.S. § 36-2158

§ 36-2158. Informed consent; fetal condition; website; unprofessional conduct; civil relief; statute of limitations; definitions

Currentness

A. A person shall not perform or induce an abortion without first obtaining the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if all of the following occur:

1. In the case of a woman seeking an abortion of her unborn child diagnosed with a lethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, that:

(a) Perinatal hospice services are available and the physician has offered this care as an alternative to abortion.

(b) The department of health services maintains a website that lists perinatal hospice programs that are available both in this state and nationally and that are organized geographically by location.

(c) The woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

2. In the case of a woman seeking an abortion of her unborn child diagnosed with a nonlethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person:

(a) Of up-to-date, evidence-based information concerning the range of outcomes for individuals living with the diagnosed condition, including physical, developmental, educational and psychosocial outcomes.

(b) That the department of health services maintains a website that lists information regarding support services, hotlines, resource centers or clearinghouses, national and local peer support groups and other education and support programs available to assist the woman and her unborn child, any national or local registries of families willing to adopt newborns with the nonlethal fetal condition and contact information for adoption agencies willing to place newborns with the nonlethal fetal condition with families willing to adopt.

(c) That the woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

(d) That § 13-3603.02 prohibits abortion because of the unborn child's sex or race or because of a genetic abnormality.

3. The woman certifies in writing before the abortion that the information required to be provided pursuant to this subsection has been provided.

B. The department of health services shall establish and annually update a website that includes the information prescribed in subsection A, paragraph 1, subdivision (b) and paragraph 2, subdivision (b) of this section.

C. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

D. In addition to other remedies available under the common or statutory law of this state, any of the following individuals may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if the father was married to the mother at the time she received the abortion, unless the pregnancy resulted from the father's criminal conduct.

3. A maternal grandparent of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the maternal grandparent's criminal conduct.

E. A civil action filed pursuant to subsection D of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to this subsection includes the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to $5,000 or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

F. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

G. For the purposes of this section:

1. “Lethal fetal condition” means a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth.

2. “Nonlethal fetal condition” means a fetal condition that is diagnosed before birth and that will not result in the death of the unborn child within three months after birth but may result in physical or mental disability or abnormality.

3. “Perinatal hospice” means comprehensive support to the pregnant woman and her family that includes supportive care from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include counseling and medical care by maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers and specialty nurses who are focused on alleviating fear and ensuring that the woman and her family experience the life and death of the child in a comfortable and supportive environment.

Credits

Added by Laws 2012, Ch. 250, § 7. Amended by Laws 2021, Ch. 286, § 11.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq.

A. R. S. § 36-2158, AZ ST § 36-2158

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 2. Abortion Reporting Requirements (Refs & Annos)

A.R.S. § 36-2161

§ 36-2161. Abortions; reporting requirements

Currentness

A. A hospital or facility in this state where abortions are performed must submit to the department of health services on a form prescribed by the department a report of each abortion performed in the hospital or facility. The report shall not identify the individual patient by name or include any other information or identifier that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or sought to obtain an abortion. The report must include the following information:

1. The name and address of the facility where the abortion was performed.

2. The type of facility where the abortion was performed.

3. The county where the abortion was performed.

4. The woman's age.

5. The woman's educational background by highest grade completed and, if applicable, level of college completed.

6. The county and state in which the woman resides.

7. The woman's race and ethnicity.

8. The woman's marital status.

9. The number of prior pregnancies and prior abortions of the woman.

10. The number of previous spontaneous terminations of pregnancy of the woman.

11. The gestational age of the unborn child at the time of the abortion.

12. The reason for the abortion, including at least one of the following:

(a) The abortion is elective.

(b) The abortion is due to maternal health considerations, including one of the following:

(i) A premature rupture of membranes.

(ii) An anatomical abnormality.

(iii) Chorioamnionitis.

(iv) Preeclampsia.

(v) Other.

(c) The abortion is due to fetal health considerations, including the fetus being diagnosed with at least one of the following:

(i) A lethal anomaly.

(ii) A central nervous system anomaly.

(iii) Other.

(d) The pregnancy is the result of a sexual assault.

(e) The pregnancy is the result of incest.

(f) The woman is being coerced into obtaining an abortion.

(g) The woman is a victim of sex trafficking.

(h) The woman is a victim of domestic violence.

(i) Other.

(j) The woman declined to answer.

13. The type of procedure performed or prescribed and the date of the abortion.

14. Any preexisting medical conditions of the woman that would complicate pregnancy.

15. Any known medical complication that resulted from the abortion, including at least one of the following:

(a) Shock.

(b) Uterine perforation.

(c) Cervical laceration requiring suture or repair.

(d) Heavy bleeding or hemorrhage with estimated blood loss of at least five hundred cubic centimeters.

(e) Aspiration or allergic response.

(f) Postprocedure infection.

(g) Sepsis.

(h) Incomplete abortion retaining part of the fetus requiring reevacuation.

(i) Damage to the uterus.

(j) Failed termination of pregnancy.

(k) Death of the patient.

(l) Other.

(m) None.

16. The basis for any medical judgment that a medical emergency existed that excused the physician from compliance with the requirements of this chapter.

17. The physician's statement if required pursuant to § 36-2301.01.

18. If applicable, the weight of the aborted fetus for any abortion performed pursuant to § 36-2301.01.

19. Whether a fetus or embryo was delivered alive as defined in § 36-2301 during or immediately after an attempted abortion and the efforts made to promote, preserve and maintain the life of the fetus or embryo pursuant to § 36-2301.

20. Statements by the physician and all clinical staff who observed the fetus or embryo during or immediately after the abortion certifying under penalty of perjury that, to the best of their knowledge, the aborted fetus or embryo was not delivered alive as defined in § 36-2301.

21. The medical specialty of the physician performing the abortion, including one of the following:

(a) Obstetrics-gynecology.

(b) General or family practice.

(c) Emergency medicine.

(d) Other.

22. The type of admission for the patient, including whether the abortion was performed:

(a) As an outpatient procedure in an abortion clinic.

(b) As an outpatient procedure at a hospital.

(c) As an inpatient procedure at a hospital.

(d) As an outpatient procedure at a health care institution other than an abortion clinic or hospital.

23. Whether anesthesia was administered to the mother.

24. Whether anesthesia was administered to the unborn child.

25. Whether any genetic abnormality of the unborn child was detected at or before the time of the abortion by genetic testing, such as maternal serum tests, or by ultrasound, such as nuchal translucency screening, or by other forms of testing.

26. If a surgical abortion was performed, the method of final disposition of bodily remains and whether the woman exercised her right to choose the final disposition of bodily remains.

B. The hospital or facility shall request the information specified in subsection A, paragraph 12 of this section at the same time the information pursuant to § 36-2153 is provided to the woman individually and in a private room to protect the woman's privacy. The information requested pursuant to subsection A, paragraph 12 of this section may be obtained on a medical form provided to the woman to complete if the woman completes the form individually and in a private room.

C. If the woman who is seeking the abortion discloses that the abortion is being sought because of a reason described in subsection A, paragraph 12, subdivision (d), (e), (f), (g) or (h) of this section, the hospital or facility shall provide the woman with information regarding the woman's right to report a crime to law enforcement and resources available for assistance and services, including a national human trafficking resource hotline.

D. The report must be signed by the physician who performed the abortion or, if a health professional other than a physician is authorized by law to prescribe or administer abortion medication, the signature and title of the person who prescribed or administered the abortion medication. The form may be signed electronically and shall indicate that the person who signs the report is attesting that the information in the report is correct to the best of the person's knowledge. The hospital or facility must transmit the report to the department within fifteen days after the last day of each reporting month.

E. Any report filed pursuant to this section shall be filed electronically at an internet website that is designated by the department unless the person required to file the report applies for a waiver from electronic reporting by submitting a written request to the department.

Credits

Added by Laws 2010, Ch. 111, § 1. Amended by Laws 2014, Ch. 33, § 3; Laws 2017, Ch. 133, § 2; Laws 2018, Ch. 219, § 1, eff. Jan. 1, 2019; Laws 2021, Ch. 286, § 13.

A. R. S. § 36-2161, AZ ST § 36-2161
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

EXHIBIT C

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2153

§ 36-2153. Informed consent; requirements; information; website; signage; violation; civil relief; statute of limitations

Currentness

A. An abortion shall not be performed or induced without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if all of the following are true:

1. At least twenty-four hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of:

(a) The name of the physician who will perform the abortion.

(b) The nature of the proposed procedure or treatment.

(c) The immediate and long-term medical risks associated with the procedure that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(d) Alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(e) The probable gestational age of the unborn child at the time the abortion is to be performed.

(f) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.

(g) The medical risks associated with carrying the child to term.

2. At least twenty-four hours before the abortion, the physician who is to perform the abortion, the referring physician or a qualified physician, physician assistant, nurse, psychologist or licensed behavioral health professional to whom the responsibility has been delegated by either physician has informed the woman, orally and in person, that:

(a) Medical assistance benefits may be available for prenatal care, childbirth and neonatal care.

(b) The father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted.

(c) Public and private agencies and services are available to assist the woman during her pregnancy and after the birth of her child if she chooses not to have an abortion, whether she chooses to keep the child or place the child for adoption.

(d) It is unlawful for any person to coerce a woman to undergo an abortion.

(e) The woman is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she might otherwise be entitled.

(f) The department of health services maintains a website that describes the unborn child and lists the agencies that offer alternatives to abortion.

(g) The woman has the right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

(h) In the case of a surgical abortion, the woman has the right to determine final disposition of bodily remains and to be informed of the available options for locations and methods for disposition of bodily remains.

3. The information in paragraphs 1 and 2 of this subsection is provided to the woman individually and in a private room to protect her privacy and to ensure that the information focuses on her individual circumstances and that she has adequate opportunity to ask questions.

4. The woman certifies in writing before the abortion that the information required to be provided pursuant to paragraphs 1 and 2 of this subsection has been provided.

5. In the case of a surgical abortion, if the woman desires to exercise her right to determine final disposition of bodily remains, the woman indicates in writing her choice for the location and method of final disposition of bodily remains.

B. If a woman has taken mifepristone as part of a two-drug regimen to terminate her pregnancy, has not yet taken the second drug and consults an abortion clinic questioning her decision to terminate her pregnancy or seeking information regarding the health of her fetus or the efficacy of mifepristone alone to terminate a pregnancy, the abortion clinic staff shall inform the woman that the use of mifepristone alone to end a pregnancy is not always effective and that she should immediately consult a physician if she would like more information.

C. If a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert the woman's death or to avert substantial and irreversible impairment of a major bodily function.

D. The department of health services shall establish and shall annually update a website that includes a link to a printable version of all materials listed on the website. The materials must be written in an easily understood manner and printed in a typeface that is large enough to be clearly legible. The website must include all of the following materials:

1. Information that is organized geographically by location and that is designed to inform the woman about public and private agencies and services that are available to assist a woman through pregnancy, at childbirth and while her child is dependent, including adoption agencies. The materials shall include a comprehensive list of the agencies, a description of the services they offer and the manner in which these agencies may be contacted, including the agencies' telephone numbers and website addresses.

2. Information on the availability of medical assistance benefits for prenatal care, childbirth and neonatal care.

3. A statement that it is unlawful for any person to coerce a woman to undergo an abortion.

4. A statement that any physician who performs an abortion on a woman without obtaining the woman's voluntary and informed consent or without affording her a private medical consultation may be liable to the woman for damages in a civil action.

5. A statement that the father of a child is liable to assist in the support of that child, even if the father has offered to pay for an abortion, and that the law allows adoptive parents to pay costs of prenatal care, childbirth and neonatal care.

6. Information that is designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including pictures or drawings representing the development of unborn children at two-week gestational increments and any relevant information on the possibility of the unborn child's survival. The pictures or drawings must contain the dimensions of the unborn child and must be realistic and appropriate for each stage of pregnancy. The information provided pursuant to this paragraph must be objective, nonjudgmental and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

7. Objective information that describes the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion and the medical risks commonly associated with carrying a child to term.

8. Information explaining the efficacy of mifepristone taken alone, without a follow-up drug as part of a two-drug regimen, to terminate a pregnancy and advising a woman to immediately contact a physician if the woman has taken only mifepristone and questions her decision to terminate her pregnancy or seeks information regarding the health of her fetus.

E. An individual who is not a physician shall not perform a surgical abortion.

F. A person shall not write or communicate a prescription for a drug or drugs to induce an abortion or require or obtain payment for a service provided to a patient who has inquired about an abortion or scheduled an abortion until the twenty-four-hour reflection period required by subsection A of this section expires.

G. A person shall not intimidate or coerce in any way any person to obtain an abortion. A parent, a guardian or any other person shall not coerce a minor to obtain an abortion. If a minor is denied financial support by the minor's parents, guardians or custodian due to the minor's refusal to have an abortion performed, the minor is deemed emancipated for the purposes of eligibility for public assistance benefits, except that the emancipated minor may not use these benefits to obtain an abortion.

H. An abortion clinic as defined in § 36-449.01 shall conspicuously post signs that are visible to all who enter the abortion clinic, that are clearly readable and that state it is unlawful for any person to force a woman to have an abortion and a woman who is being forced to have an abortion has the right to contact any local or state law enforcement or social service agency to receive protection from any actual or threatened physical, emotional or psychological abuse. The signs shall be posted in the waiting room, consultation rooms and procedure rooms.

I. A person shall not require a woman to obtain an abortion as a provision in a contract or as a condition of employment.

J. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

K. In addition to other remedies available under the common or statutory law of this state, any of the following may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if the father was married to the mother at the time she received the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

3. A maternal grandparent of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

L. A civil action filed pursuant to subsection K of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to subsection K of this section includes the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to $5,000 or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

M. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

Credits

Added by Laws 2009, Ch. 172, § 4. Amended by Laws 2012, Ch. 250, § 5; Laws 2015, Ch. 87, § 4; Laws 2016, Ch. 267, § 5; Laws 2021, Ch. 286, § 9.

Footnotes

1 Section 32-1401 et seq., or 32-1800 et seq.

A. R. S. § 36-2153, AZ ST § 36-2153
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

A.R.S. § 36-2158

§ 36-2158. Informed consent; fetal condition; website; unprofessional conduct; civil relief; statute of limitations; definitions

Currentness

A. A person shall not perform or induce an abortion without first obtaining the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if all of the following occur:

1. In the case of a woman seeking an abortion of her unborn child diagnosed with a lethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, that:

(a) Perinatal hospice services are available and the physician has offered this care as an alternative to abortion.

(b) The department of health services maintains a website that lists perinatal hospice programs that are available both in this state and nationally and that are organized geographically by location.

(c) The woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

2. In the case of a woman seeking an abortion of her unborn child diagnosed with a nonlethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person:

(a) Of up-to-date, evidence-based information concerning the range of outcomes for individuals living with the diagnosed condition, including physical, developmental, educational and psychosocial outcomes.

(b) That the department of health services maintains a website that lists information regarding support services, hotlines, resource centers or clearinghouses, national and local peer support groups and other education and support programs available to assist the woman and her unborn child, any national or local registries of families willing to adopt newborns with the nonlethal fetal condition and contact information for adoption agencies willing to place newborns with the nonlethal fetal condition with families willing to adopt.

(c) That the woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

(d) That § 13-3603.02 prohibits abortion because of the unborn child's sex or race or because of a genetic abnormality.

3. The woman certifies in writing before the abortion that the information required to be provided pursuant to this subsection has been provided.

B. The department of health services shall establish and annually update a website that includes the information prescribed in subsection A, paragraph 1, subdivision (b) and paragraph 2, subdivision (b) of this section.

C. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

D. In addition to other remedies available under the common or statutory law of this state, any of the following individuals may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if the father was married to the mother at the time she received the abortion, unless the pregnancy resulted from the father's criminal conduct.

3. A maternal grandparent of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the maternal grandparent's criminal conduct.

E. A civil action filed pursuant to subsection D of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to this subsection includes the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to $5,000 or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

F. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

G. For the purposes of this section:

1. “Lethal fetal condition” means a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth.

2. “Nonlethal fetal condition” means a fetal condition that is diagnosed before birth and that will not result in the death of the unborn child within three months after birth but may result in physical or mental disability or abnormality.

3. “Perinatal hospice” means comprehensive support to the pregnant woman and her family that includes supportive care from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include counseling and medical care by maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers and specialty nurses who are focused on alleviating fear and ensuring that the woman and her family experience the life and death of the child in a comfortable and supportive environment.

Credits

Added by Laws 2012, Ch. 250, § 7. Amended by Laws 2021, Ch. 286, § 11.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq.

A. R. S. § 36-2158, AZ ST § 36-2158

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2156

§ 36-2156. Informed consent; ultrasound required; violation; civil relief; statute of limitations

Currentness

A. An abortion shall not be performed or induced without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if both of the following are true:

1. At least twenty-four hours before the woman having any part of an abortion performed or induced, and before the administration of any anesthesia or medication in preparation for the abortion on the woman, the physician who is to perform the abortion, the referring physician or a qualified person working in conjunction with either physician shall:

(a) Perform fetal ultrasound imaging and auscultation of fetal heart tone services on the woman undergoing the abortion.

(b) Offer to provide the woman with an opportunity to view the active ultrasound image of the unborn child and hear the heartbeat of the unborn child if the heartbeat is audible. The active ultrasound image must be of a quality consistent with standard medical practice in the community, contain the dimensions of the unborn child and accurately portray the presence of external members and internal organs, if present or viewable, of the unborn child. The auscultation of fetal heart tone must be of a quality consistent with standard medical practice in the community.

(c) Offer to provide the woman with a simultaneous explanation of what the ultrasound is depicting, including the presence and location of the unborn child within the uterus, the number of unborn children depicted, the dimensions of the unborn child and the presence of any external members and internal organs, if present or viewable.

(d) Offer to provide the patient with a physical picture of the ultrasound image of the unborn child.

2. The woman certifies in writing before the abortion that she has been given the opportunity to view the active ultrasound image and hear the heartbeat of the unborn child if the heartbeat is audible and that she opted to view or not view the active ultrasound image and hear or not hear the heartbeat of the unborn child.

B. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

C. In addition to other remedies available under the common or statutory law of this state, any of the following may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if married to the mother at the time she received the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

3. The maternal grandparents of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

D. A civil action filed pursuant to subsection C of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to subsection C of this section includes any of the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to five thousand dollars or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

E. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

Credits
Added by Laws 2011, Ch. 10, § 5. Amended by Laws 2012, Ch. 250, § 6.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq.

A. R. S. § 36-2156, AZ ST § 36-2156
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

A.R.S. § 36-2162.01

§ 36-2162.01. Informed consent; reporting requirements

Currentness

A. A physician in this state who provides informed consent information regarding abortion pursuant to § 36-2153 or performs fetal ultrasound imaging and auscultation of fetal heart tone services pursuant to § 36-2156 or who delegates to a person authorized by § 36-2153 or 36-2156 the duty to provide the information or services required by those sections shall submit to the department of health services on a form prescribed by the department a report that includes the following information:

1. The number of women to whom the physician provided the information described in § 36-2153, subsection A, paragraph 1, and, of those women, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion.

2. The number of women to whom the physician, physician assistant, nurse, psychologist or licensed behavioral health professional provided the information described in § 36-2153, subsection A, paragraph 2, and, of those women, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion, and, of each of those numbers, the number provided by the physician and the number provided by a physician assistant, nurse, psychologist or licensed behavioral health professional.

3. The number of women for whom the physician or qualified person working in conjunction with the physician performed fetal ultrasound imaging and auscultation of fetal heart tone services described in § 36-2156, subsection A, paragraph 1, and, of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion, and, of each of those numbers, the number provided by the physician and the number provided by a qualified person working in conjunction with the physician.

4. The number of abortions performed by the physician in which information required by §§ 36-2153 and 36-2156 to be provided at least twenty-four hours before the abortion was not provided because a medical emergency compelled the performance of an abortion to avert the woman's death and the number of abortions in which this required information was not provided because a medical emergency compelled the performance of an abortion to avert substantial and irreversible impairment of a major bodily function of the woman.

B. The report may not identify the individual patient by name or include any other information or identifier that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or sought to obtain an abortion.

C. The report shall be signed by the physician who provided to the woman the information required by § 36-2153, subsection A, paragraph 1 or the physician who delegated the duty to another person authorized by law to provide to the woman the

information required by § 36-2153, subsection A, paragraph 2 or § 36-2156, subsection A, paragraph 1. The form may be signed electronically and shall indicate that the physician who signs the report is attesting that the information in the report is correct to the best of the physician's knowledge. The physician must transmit the report to the department within fifteen days after the last day of each reporting month.

D. Any report filed pursuant to this section shall be filed electronically at an internet website that is designated by the department unless the person required to file the report applies for a waiver from electronic reporting by submitting a written request to the department.

Credits

Added by Laws 2018, Ch. 219, § 3, eff. Jan. 1, 2019.

A. R. S. § 36-2162.01, AZ ST § 36-2162.01

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 4. Health Care Institutions (Refs & Annos)
Article 10. Abortion Clinics (Refs & Annos)

A.R.S. § 36-449.03

§ 36-449.03. Abortion clinics; rules; civil penalties

Currentness

A. The director shall adopt rules for an abortion clinic's physical facilities. At a minimum these rules shall prescribe standards for:

1. Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.

2. Dressing rooms for staff and patients.

3. Appropriate lavatory areas.

4. Areas for preprocedure hand washing.

5. Private procedure rooms.

6. Adequate lighting and ventilation for abortion procedures.

7. Surgical or gynecologic examination tables and other fixed equipment.

8. Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.

9. Emergency exits to accommodate a stretcher or gurney.

10. Areas for cleaning and sterilizing instruments.

11. Adequate areas to securely store medical records and necessary equipment and supplies.

12. The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.

B. The director shall adopt rules to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum these rules shall:

1. Prescribe required equipment and supplies, including medications, required to conduct, in an appropriate fashion, any abortion procedure that the medical staff of the clinic anticipates performing and to monitor the progress of each patient throughout the procedure and recovery period.

2. Require that the number or amount of equipment and supplies at the clinic is adequate at all times to ensure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.

3. Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.

4. Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.

5. Require ultrasound equipment.

6. Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.

C. The director shall adopt rules relating to abortion clinic personnel. At a minimum these rules shall require that:

1. The abortion clinic designate a medical director of the abortion clinic who is licensed pursuant to title 32, chapter 13, 17 or 29. [1]

2. Physicians performing abortions are licensed pursuant to title 32, chapter 13 or 17, demonstrate competence in the procedure involved and are acceptable to the medical director of the abortion clinic.

3. A physician is available:

(a) For a surgical abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B and that is within thirty miles of the abortion clinic.

(b) For a medication abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B.

4. If a physician is not present, a registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care, or monitoring and care after inducing a medication abortion, until each patient who had an abortion that day is discharged.

5. Surgical assistants receive training in counseling, patient advocacy and the specific responsibilities of the services the surgical assistants provide.

6. Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

D. The director shall adopt rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules shall require:

1. A medical history, including the following:

(a) Reported allergies to medications, antiseptic solutions or latex.

(b) Obstetric and gynecologic history.

(c) Past surgeries.

2. A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa.

3. The appropriate laboratory tests, including:

(a) Urine or blood tests for pregnancy performed before the abortion procedure.

(b) A test for anemia.

(c) Rh typing, unless reliable written documentation of blood type is available.

(d) Other tests as indicated from the physical examination.

4. An ultrasound evaluation for all patients. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in operating ultrasound equipment as prescribed in rule. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.

5. That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule and shall write the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

E. The director shall adopt rules relating to the abortion procedure. At a minimum these rules shall require:

1. That medical personnel is available to all patients throughout the abortion procedure.

2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.

3. Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.

4. The use of appropriate precautions, such as establishing intravenous access at least for patients undergoing second or third trimester abortions.

5. The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

6. For abortion clinics performing or inducing an abortion for a woman whose unborn child is the gestational age of twenty weeks or more, minimum equipment standards to assist the physician in complying with § 36-2301. For the purposes of this paragraph, “abortion” and “gestational age” have the same meanings prescribed in § 36-2151.

F. The director shall adopt rules relating to the final disposition of bodily remains. At a minimum these rules shall require that:

1. The final disposition of bodily remains from a surgical abortion be by cremation or interment.

2. For a surgical abortion, the woman on whom the abortion is performed has the right to determine the method and location for final disposition of bodily remains.

G. The director shall adopt rules that prescribe minimum recovery room standards. At a minimum these rules shall require that:

1. For a surgical abortion, immediate postprocedure care, or care provided after inducing a medication abortion, consists of observation in a supervised recovery room for as long as the patient's condition warrants.

2. The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.

3. A licensed health professional who is trained in managing the recovery area and who is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.

4. For a surgical abortion, a physician with admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B and that is within thirty miles of the abortion clinic remains on the premises of the abortion clinic until all patients are stable and are ready to leave the recovery room and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged.

5. A physician discusses RhO(d) immune globulin with each patient for whom it is indicated and ensures that it is offered to the patient in the immediate postoperative period or that it will be available to her within seventy-two hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.

6. Written instructions with regard to postabortion coitus, signs of possible problems and general aftercare are given to each patient. Each patient shall have specific instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies.

7. There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and duration of gestation.

8. The physician ensures that a licensed health professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within twenty-four hours after a surgical abortion to assess the patient's recovery.

9. Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

H. The director shall adopt rules that prescribe standards for follow-up visits. At a minimum these rules shall require that:

1. For a surgical abortion, a postabortion medical visit is offered and, if requested, scheduled for three weeks after the abortion, including a medical examination and a review of the results of all laboratory tests. For a medication abortion, the rules shall require that a postabortion medical visit is scheduled between one week and three weeks after the initial dose for a medication abortion to confirm the pregnancy is completely terminated and to assess the degree of bleeding.

2. A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.

I. The director shall adopt rules to prescribe minimum abortion clinic incident reporting. At a minimum these rules shall require that:

1. The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within ten days after the incident. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ and includes any injury or condition that requires ambulance transportation of the patient.

2. If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic reports it to the department not later than the next department work day.

3. Incident reports are filed with the department and appropriate professional regulatory boards.

J. The director shall adopt rules relating to enforcement of this article. At a minimum, these rules shall require that:

1. For an abortion clinic that is not in substantial compliance with this article and the rules adopted pursuant to this article and § 36-2301 or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the department of any deficiencies that are listed on the department's statement of deficiency, the department may do any of the following:

(a) Assess a civil penalty pursuant to § 36-431.01.

(b) Impose an intermediate sanction pursuant to § 36-427.

(c) Suspend or revoke a license pursuant to § 36-427.

(d) Deny a license.

(e) Bring an action for an injunction pursuant to § 36-430.

2. In determining the appropriate enforcement action, the department consider the threat to the health, safety and welfare of the abortion clinic's patients or the general public, including:

(a) Whether the abortion clinic has repeated violations of statutes or rules.

(b) Whether the abortion clinic has engaged in a pattern of noncompliance.

(c) The type, severity and number of violations.

K. The department shall not release personally identifiable patient or physician information.

L. The rules adopted by the director pursuant to this section do not limit the ability of a physician or other health professional to advise a patient on any health issue.

Credits

Added by Laws 1999, Ch. 311, § 2. Amended by Laws 2000, Ch. 365, § 1; Laws 2012, Ch. 250, § 2; Laws 2016, Ch. 75, § 1; Laws 2016, Ch. 267, § 4; Laws 2017, Ch. 133, § 1; Laws 2021, Ch. 286, § 7.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq., 32-2901 et seq.

A. R. S. § 36-449.03, AZ ST § 36-449.03

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Administrative Code
Title 9. Health Services
Chapter 10. Department of Health Services Health Care Institutions: Licensing (Refs & Annos)
Article 15. Abortion Clinics (Refs & Annos)

A.A.C. R9-10-1509
Formerly cited as AZ ADC R9-10-1508

R9-10-1509. Abortion Procedures

Currentness

A. A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:

1. A medical history including:

   a. Allergies to medications, antiseptic solutions, or latex;

   b. Obstetrical and gynecological history;

   c. Past surgeries;

   d. Medication the patient is currently taking; and

   e. Other medical conditions;

2. A physical examination, performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa;

3. The following laboratory tests:

   a. A urine or blood test to determine pregnancy;

   b. Rh typing, unless the patient provides written documentation of blood type acceptable to the physician;

   c. Anemia screening; and

   d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination; and

4. An ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A).

B. If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:

1. The patient receives information from a physician on this condition;

2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;

3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;

4. The form in subsection (B)(3) is maintained in the patient's medical record; and

5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.

C. A physician shall estimate the gestational age of the fetus, based on one of the following criteria, and record the estimated gestational age in the patient's medical record:

1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or

2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.

D. A medical director shall ensure that:

1. The ultrasound of a patient required in subsection (A)(4) is performed by an individual who meets the requirements in R9-10-1506(3);

2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts in a publication distributed nationally that contains peer-reviewed medical information, such as medical information derived from a publication describing research in obstetrics and gynecology or in diagnostic imaging;

3. An original patient ultrasound image is:

a. Interpreted by a physician, and

b. Maintained in the patient's medical record in either electronic or paper form; and

4. If requested by the patient, the ultrasound image is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.

E. A medical director shall ensure that before an abortion is performed on a patient:

1. Written consent, that meets the requirements in A.R.S. § 36-2152 or 36-2153, as applicable, and A.R.S. § 36-2158 is signed and dated by the patient or the patient's representative;

2. Information is provided to the patient on the abortion procedure, including alternatives, risks, and potential complications;

3. Information specified in A.R.S. § 36-2161(A)(12) is requested from the patient; and

4. If applicable, information required in A.R.S. § 36-2161(C) is provided to the patient.

F. A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.

G. A medical director shall ensure that:

1. A patient care staff member monitors a patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;

2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record;

3. If an abortion procedure is performed at or after 20 weeks gestational age, a patient care staff member qualified in neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure takes place before the delivery of the fetus; and

4. If a fetus is delivered alive:

a. Resuscitative measures, including the following, are used to support life:

i. Warming and drying of the fetus,

ii. Clearing secretions from and positioning the airway of the fetus,

iii. Administering oxygen as needed to the fetus, and

iv. Assessing and monitoring the cardiopulmonary status of the fetus;

b. A determination is made of whether the fetus is a viable fetus;

c. A viable fetus is provided treatment to support life;

d. A viable fetus is transferred as required in R9-10-1510; and

e. Resuscitative measures and the transfer, as applicable, are documented.

H. To ensure a patient's health and safety, a medical director shall ensure that following the abortion procedure:

1. A patient's vital signs and bleeding are monitored by:

a. A physician;

b. A physician assistant;

c. A registered nurse practitioner;

d. A nurse; or

e. If a physician is able to provide direct supervision, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, to a medical assistant, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, a medical assistant under the direct supervision of the physician; and

2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner, or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.

I. A medical director shall ensure that follow-up care:

1. For a surgical abortion is offered to a patient that includes:

a. With a patient's consent, a telephone call made to the patient to assess the patient's recovery:

i. By a patient care staff member other than a surgical assistant; and

ii. Within 24 hours after the patient's discharge following a surgical abortion; and

b. A follow-up visit scheduled, if requested, no more than 21 calendar days after the abortion that includes:

i. A physical examination,

ii. A review of all laboratory tests as required in subsection (A)(3), and

iii. A urine pregnancy test;

2. For a medication abortion includes a follow-up visit, scheduled between seven and 21 calendar days after the initial dose of a substance used to induce an abortion, that includes:

a. A urine pregnancy test, and

b. An assessment of the degree of bleeding; and

3. Is documented in the patient's medical record, including:

a. A patient's acceptance or refusal of a follow-up visit following a surgical abortion;

b. If applicable, the results of the follow-up visit; and

c. If applicable, whether the patient consented to a telephone call and, if so, whether the patient care staff member making the telephone call to the patient:

i. Spoke with the patient about the patient's recovery, or

ii. Was unable to speak with the patient.

J. If a continuing pregnancy is suspected as a result of the follow-up visit in subsection (I)(1)(b) or (I)(2), a physician who performs abortions shall be consulted.

Credits

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Former R9-10-1509 renumbered to R9-10-1510; new R9-10-1509 renumbered from R9-10-1508 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018. Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019.

Current through rules published in Arizona Administrative Register Volume 31, Issue 19 May 9, 2025. Some sections may be more current. See credits for details.

A.A.C. R9-10-1509, AZ ADC R9-10-1509

End of Document

EXHIBIT D

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2153

§ 36-2153. Informed consent; requirements; information; website; signage; violation; civil relief; statute of limitations

Currentness

A. An abortion shall not be performed or induced without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if all of the following are true:

1. At least twenty-four hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of:

(a) The name of the physician who will perform the abortion.

(b) The nature of the proposed procedure or treatment.

(c) The immediate and long-term medical risks associated with the procedure that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(d) Alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(e) The probable gestational age of the unborn child at the time the abortion is to be performed.

(f) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.

(g) The medical risks associated with carrying the child to term.

2. At least twenty-four hours before the abortion, the physician who is to perform the abortion, the referring physician or a qualified physician, physician assistant, nurse, psychologist or licensed behavioral health professional to whom the responsibility has been delegated by either physician has informed the woman, orally and in person, that:

(a) Medical assistance benefits may be available for prenatal care, childbirth and neonatal care.

(b) The father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted.

(c) Public and private agencies and services are available to assist the woman during her pregnancy and after the birth of her child if she chooses not to have an abortion, whether she chooses to keep the child or place the child for adoption.

(d) It is unlawful for any person to coerce a woman to undergo an abortion.

(e) The woman is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she might otherwise be entitled.

(f) The department of health services maintains a website that describes the unborn child and lists the agencies that offer alternatives to abortion.

(g) The woman has the right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

(h) In the case of a surgical abortion, the woman has the right to determine final disposition of bodily remains and to be informed of the available options for locations and methods for disposition of bodily remains.

3. The information in paragraphs 1 and 2 of this subsection is provided to the woman individually and in a private room to protect her privacy and to ensure that the information focuses on her individual circumstances and that she has adequate opportunity to ask questions.

4. The woman certifies in writing before the abortion that the information required to be provided pursuant to paragraphs 1 and 2 of this subsection has been provided.

5. In the case of a surgical abortion, if the woman desires to exercise her right to determine final disposition of bodily remains, the woman indicates in writing her choice for the location and method of final disposition of bodily remains.

B. If a woman has taken mifepristone as part of a two-drug regimen to terminate her pregnancy, has not yet taken the second drug and consults an abortion clinic questioning her decision to terminate her pregnancy or seeking information regarding the health of her fetus or the efficacy of mifepristone alone to terminate a pregnancy, the abortion clinic staff shall inform the woman that the use of mifepristone alone to end a pregnancy is not always effective and that she should immediately consult a physician if she would like more information.

C. If a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert the woman's death or to avert substantial and irreversible impairment of a major bodily function.

D. The department of health services shall establish and shall annually update a website that includes a link to a printable version of all materials listed on the website. The materials must be written in an easily understood manner and printed in a typeface that is large enough to be clearly legible. The website must include all of the following materials:

1. Information that is organized geographically by location and that is designed to inform the woman about public and private agencies and services that are available to assist a woman through pregnancy, at childbirth and while her child is dependent, including adoption agencies. The materials shall include a comprehensive list of the agencies, a description of the services they offer and the manner in which these agencies may be contacted, including the agencies' telephone numbers and website addresses.

2. Information on the availability of medical assistance benefits for prenatal care, childbirth and neonatal care.

3. A statement that it is unlawful for any person to coerce a woman to undergo an abortion.

4. A statement that any physician who performs an abortion on a woman without obtaining the woman's voluntary and informed consent or without affording her a private medical consultation may be liable to the woman for damages in a civil action.

5. A statement that the father of a child is liable to assist in the support of that child, even if the father has offered to pay for an abortion, and that the law allows adoptive parents to pay costs of prenatal care, childbirth and neonatal care.

6. Information that is designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including pictures or drawings representing the development of unborn children at two-week gestational increments and any relevant information on the possibility of the unborn child's survival. The pictures or drawings must contain the dimensions of the unborn child and must be realistic and appropriate for each stage of pregnancy. The information provided pursuant to this paragraph must be objective, nonjudgmental and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

7. Objective information that describes the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion and the medical risks commonly associated with carrying a child to term.

8. Information explaining the efficacy of mifepristone taken alone, without a follow-up drug as part of a two-drug regimen, to terminate a pregnancy and advising a woman to immediately contact a physician if the woman has taken only mifepristone and questions her decision to terminate her pregnancy or seeks information regarding the health of her fetus.

E. An individual who is not a physician shall not perform a surgical abortion.

F. A person shall not write or communicate a prescription for a drug or drugs to induce an abortion or require or obtain payment for a service provided to a patient who has inquired about an abortion or scheduled an abortion until the twenty-four-hour reflection period required by subsection A of this section expires.

G. A person shall not intimidate or coerce in any way any person to obtain an abortion. A parent, a guardian or any other person shall not coerce a minor to obtain an abortion. If a minor is denied financial support by the minor's parents, guardians or custodian due to the minor's refusal to have an abortion performed, the minor is deemed emancipated for the purposes of eligibility for public assistance benefits, except that the emancipated minor may not use these benefits to obtain an abortion.

H. An abortion clinic as defined in § 36-449.01 shall conspicuously post signs that are visible to all who enter the abortion clinic, that are clearly readable and that state it is unlawful for any person to force a woman to have an abortion and a woman who is being forced to have an abortion has the right to contact any local or state law enforcement or social service agency to receive protection from any actual or threatened physical, emotional or psychological abuse. The signs shall be posted in the waiting room, consultation rooms and procedure rooms.

I. A person shall not require a woman to obtain an abortion as a provision in a contract or as a condition of employment.

J. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

K. In addition to other remedies available under the common or statutory law of this state, any of the following may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if the father was married to the mother at the time she received the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

3. A maternal grandparent of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

L. A civil action filed pursuant to subsection K of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to subsection K of this section includes the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to $5,000 or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

M. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

Credits

Added by Laws 2009, Ch. 172, § 4. Amended by Laws 2012, Ch. 250, § 5; Laws 2015, Ch. 87, § 4; Laws 2016, Ch. 267, § 5; Laws 2021, Ch. 286, § 9.

Footnotes

1 Section 32-1401 et seq., or 32-1800 et seq.

A. R. S. § 36-2153, AZ ST § 36-2153
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2156

§ 36-2156. Informed consent; ultrasound required; violation; civil relief; statute of limitations

Currentness

A. An abortion shall not be performed or induced without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if both of the following are true:

1. At least twenty-four hours before the woman having any part of an abortion performed or induced, and before the administration of any anesthesia or medication in preparation for the abortion on the woman, the physician who is to perform the abortion, the referring physician or a qualified person working in conjunction with either physician shall:

(a) Perform fetal ultrasound imaging and auscultation of fetal heart tone services on the woman undergoing the abortion.

(b) Offer to provide the woman with an opportunity to view the active ultrasound image of the unborn child and hear the heartbeat of the unborn child if the heartbeat is audible. The active ultrasound image must be of a quality consistent with standard medical practice in the community, contain the dimensions of the unborn child and accurately portray the presence of external members and internal organs, if present or viewable, of the unborn child. The auscultation of fetal heart tone must be of a quality consistent with standard medical practice in the community.

(c) Offer to provide the woman with a simultaneous explanation of what the ultrasound is depicting, including the presence and location of the unborn child within the uterus, the number of unborn children depicted, the dimensions of the unborn child and the presence of any external members and internal organs, if present or viewable.

(d) Offer to provide the patient with a physical picture of the ultrasound image of the unborn child.

2. The woman certifies in writing before the abortion that she has been given the opportunity to view the active ultrasound image and hear the heartbeat of the unborn child if the heartbeat is audible and that she opted to view or not view the active ultrasound image and hear or not hear the heartbeat of the unborn child.

B. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

C. In addition to other remedies available under the common or statutory law of this state, any of the following may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if married to the mother at the time she received the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

3. The maternal grandparents of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the plaintiff's criminal conduct.

D. A civil action filed pursuant to subsection C of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to subsection C of this section includes any of the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to five thousand dollars or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

E. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

Credits
Added by Laws 2011, Ch. 10, § 5. Amended by Laws 2012, Ch. 250, § 6.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq.

A. R. S. § 36-2156, AZ ST § 36-2156
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

A.R.S. § 36-2158

§ 36-2158. Informed consent; fetal condition; website; unprofessional conduct; civil relief; statute of limitations; definitions

Currentness

A. A person shall not perform or induce an abortion without first obtaining the voluntary and informed consent of the woman on whom the abortion is to be performed or induced. Except in the case of a medical emergency and in addition to the other requirements of this chapter, consent to an abortion is voluntary and informed only if all of the following occur:

1. In the case of a woman seeking an abortion of her unborn child diagnosed with a lethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, that:

(a) Perinatal hospice services are available and the physician has offered this care as an alternative to abortion.

(b) The department of health services maintains a website that lists perinatal hospice programs that are available both in this state and nationally and that are organized geographically by location.

(c) The woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

2. In the case of a woman seeking an abortion of her unborn child diagnosed with a nonlethal fetal condition, at least twenty-four hours before the abortion the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person:

(a) Of up-to-date, evidence-based information concerning the range of outcomes for individuals living with the diagnosed condition, including physical, developmental, educational and psychosocial outcomes.

(b) That the department of health services maintains a website that lists information regarding support services, hotlines, resource centers or clearinghouses, national and local peer support groups and other education and support programs available to assist the woman and her unborn child, any national or local registries of families willing to adopt newborns with the nonlethal fetal condition and contact information for adoption agencies willing to place newborns with the nonlethal fetal condition with families willing to adopt.

(c) That the woman has a right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials.

(d) That § 13-3603.02 prohibits abortion because of the unborn child's sex or race or because of a genetic abnormality.

3. The woman certifies in writing before the abortion that the information required to be provided pursuant to this subsection has been provided.

B. The department of health services shall establish and annually update a website that includes the information prescribed in subsection A, paragraph 1, subdivision (b) and paragraph 2, subdivision (b) of this section.

C. A physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17. [1]

D. In addition to other remedies available under the common or statutory law of this state, any of the following individuals may file a civil action to obtain appropriate relief for a violation of this section:

1. A woman on whom an abortion has been performed without her informed consent as required by this section.

2. The father of the unborn child if the father was married to the mother at the time she received the abortion, unless the pregnancy resulted from the father's criminal conduct.

3. A maternal grandparent of the unborn child if the mother was not at least eighteen years of age at the time of the abortion, unless the pregnancy resulted from the maternal grandparent's criminal conduct.

E. A civil action filed pursuant to subsection D of this section shall be brought in the superior court in the county in which the woman on whom the abortion was performed resides and may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, wilfulness, intention or any other legal standard of care. Relief pursuant to this subsection includes the following:

1. Money damages for all psychological, emotional and physical injuries resulting from the violation of this section.

2. Statutory damages in an amount equal to $5,000 or three times the cost of the abortion, whichever is greater.

3. Reasonable attorney fees and costs.

F. A civil action brought pursuant to this section must be initiated within six years after the violation occurred.

G. For the purposes of this section:

1. “Lethal fetal condition” means a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth.

2. “Nonlethal fetal condition” means a fetal condition that is diagnosed before birth and that will not result in the death of the unborn child within three months after birth but may result in physical or mental disability or abnormality.

3. “Perinatal hospice” means comprehensive support to the pregnant woman and her family that includes supportive care from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include counseling and medical care by maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers and specialty nurses who are focused on alleviating fear and ensuring that the woman and her family experience the life and death of the child in a comfortable and supportive environment.

Credits

Added by Laws 2012, Ch. 250, § 7. Amended by Laws 2021, Ch. 286, § 11.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq.

A. R. S. § 36-2158, AZ ST § 36-2158

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

A.R.S. § 36-3604

§ 36-3604. Use of telehealth for abortion prohibited; penalty; definition

Currentness

A. A health care provider shall not use telehealth to provide an abortion.

B. A health care provider who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32. [1]

C. For the purposes of this section, "abortion" has the same meaning prescribed in § 36-2151.

Credits
Added by Laws 2011, Ch. 10, § 6. Amended by Laws 2021, Ch. 320, § 17, eff. May 5, 2021.

Footnotes

1 Section 32-101 et seq.

A. R. S. § 36-3604, AZ ST § 36-3604
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 20. Abortion (Refs & Annos)
Article 1. General Provisions (Refs & Annos)

A.R.S. § 36-2160

§ 36-2160. Abortion-inducing drugs; definition

Currentness

A. An abortion-inducing drug may be provided only by a qualified physician in accordance with the requirements of this chapter.

B. A manufacturer, supplier or physician or any other person is prohibited from providing an abortion-inducing drug via courier, delivery or mail service.

C. This section does not apply to drugs that may be known to cause an abortion but that are prescribed for other medical indications.

D. For the purposes of this section, "abortion-inducing drug" means a medicine or drug or any other substance used for a medication abortion.

Credits
Added by Laws 2021, Ch. 286, § 12.

A. R. S. § 36-2160, AZ ST § 36-2160
Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Revised Statutes Annotated
Title 36. Public Health and Safety (Refs & Annos)
Chapter 4. Health Care Institutions (Refs & Annos)
Article 10. Abortion Clinics (Refs & Annos)

A.R.S. § 36-449.03

§ 36-449.03. Abortion clinics; rules; civil penalties

Currentness

A. The director shall adopt rules for an abortion clinic's physical facilities. At a minimum these rules shall prescribe standards for:

1. Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.

2. Dressing rooms for staff and patients.

3. Appropriate lavatory areas.

4. Areas for preprocedure hand washing.

5. Private procedure rooms.

6. Adequate lighting and ventilation for abortion procedures.

7. Surgical or gynecologic examination tables and other fixed equipment.

8. Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.

9. Emergency exits to accommodate a stretcher or gurney.

10. Areas for cleaning and sterilizing instruments.

11. Adequate areas to securely store medical records and necessary equipment and supplies.

12. The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.

B. The director shall adopt rules to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum these rules shall:

1. Prescribe required equipment and supplies, including medications, required to conduct, in an appropriate fashion, any abortion procedure that the medical staff of the clinic anticipates performing and to monitor the progress of each patient throughout the procedure and recovery period.

2. Require that the number or amount of equipment and supplies at the clinic is adequate at all times to ensure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.

3. Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.

4. Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.

5. Require ultrasound equipment.

6. Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.

C. The director shall adopt rules relating to abortion clinic personnel. At a minimum these rules shall require that:

1. The abortion clinic designate a medical director of the abortion clinic who is licensed pursuant to title 32, chapter 13, 17 or 29. [1]

2. Physicians performing abortions are licensed pursuant to title 32, chapter 13 or 17, demonstrate competence in the procedure involved and are acceptable to the medical director of the abortion clinic.

3. A physician is available:

(a) For a surgical abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B and that is within thirty miles of the abortion clinic.

(b) For a medication abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B.

4. If a physician is not present, a registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care, or monitoring and care after inducing a medication abortion, until each patient who had an abortion that day is discharged.

5. Surgical assistants receive training in counseling, patient advocacy and the specific responsibilities of the services the surgical assistants provide.

6. Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

D. The director shall adopt rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules shall require:

1. A medical history, including the following:

(a) Reported allergies to medications, antiseptic solutions or latex.

(b) Obstetric and gynecologic history.

(c) Past surgeries.

2. A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa.

3. The appropriate laboratory tests, including:

(a) Urine or blood tests for pregnancy performed before the abortion procedure.

(b) A test for anemia.

(c) Rh typing, unless reliable written documentation of blood type is available.

(d) Other tests as indicated from the physical examination.

4. An ultrasound evaluation for all patients. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in operating ultrasound equipment as prescribed in rule. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.

5. That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule and shall write the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

E. The director shall adopt rules relating to the abortion procedure. At a minimum these rules shall require:

1. That medical personnel is available to all patients throughout the abortion procedure.

2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.

3. Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.

4. The use of appropriate precautions, such as establishing intravenous access at least for patients undergoing second or third trimester abortions.

5. The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

6. For abortion clinics performing or inducing an abortion for a woman whose unborn child is the gestational age of twenty weeks or more, minimum equipment standards to assist the physician in complying with § 36-2301. For the purposes of this paragraph, “abortion” and “gestational age” have the same meanings prescribed in § 36-2151.

F. The director shall adopt rules relating to the final disposition of bodily remains. At a minimum these rules shall require that:

1. The final disposition of bodily remains from a surgical abortion be by cremation or interment.

2. For a surgical abortion, the woman on whom the abortion is performed has the right to determine the method and location for final disposition of bodily remains.

G. The director shall adopt rules that prescribe minimum recovery room standards. At a minimum these rules shall require that:

1. For a surgical abortion, immediate postprocedure care, or care provided after inducing a medication abortion, consists of observation in a supervised recovery room for as long as the patient's condition warrants.

2. The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.

3. A licensed health professional who is trained in managing the recovery area and who is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.

4. For a surgical abortion, a physician with admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B and that is within thirty miles of the abortion clinic remains on the premises of the abortion clinic until all patients are stable and are ready to leave the recovery room and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged.

5. A physician discusses RhO(d) immune globulin with each patient for whom it is indicated and ensures that it is offered to the patient in the immediate postoperative period or that it will be available to her within seventy-two hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.

6. Written instructions with regard to postabortion coitus, signs of possible problems and general aftercare are given to each patient. Each patient shall have specific instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies.

7. There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and duration of gestation.

8. The physician ensures that a licensed health professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within twenty-four hours after a surgical abortion to assess the patient's recovery.

9. Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

H. The director shall adopt rules that prescribe standards for follow-up visits. At a minimum these rules shall require that:

1. For a surgical abortion, a postabortion medical visit is offered and, if requested, scheduled for three weeks after the abortion, including a medical examination and a review of the results of all laboratory tests. For a medication abortion, the rules shall require that a postabortion medical visit is scheduled between one week and three weeks after the initial dose for a medication abortion to confirm the pregnancy is completely terminated and to assess the degree of bleeding.

2. A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.

I. The director shall adopt rules to prescribe minimum abortion clinic incident reporting. At a minimum these rules shall require that:

1. The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within ten days after the incident. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ and includes any injury or condition that requires ambulance transportation of the patient.

2. If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic reports it to the department not later than the next department work day.

3. Incident reports are filed with the department and appropriate professional regulatory boards.

J. The director shall adopt rules relating to enforcement of this article. At a minimum, these rules shall require that:

1. For an abortion clinic that is not in substantial compliance with this article and the rules adopted pursuant to this article and § 36-2301 or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the department of any deficiencies that are listed on the department's statement of deficiency, the department may do any of the following:

(a) Assess a civil penalty pursuant to § 36-431.01.

(b) Impose an intermediate sanction pursuant to § 36-427.

(c) Suspend or revoke a license pursuant to § 36-427.

(d) Deny a license.

(e) Bring an action for an injunction pursuant to § 36-430.

2. In determining the appropriate enforcement action, the department consider the threat to the health, safety and welfare of the abortion clinic's patients or the general public, including:

(a) Whether the abortion clinic has repeated violations of statutes or rules.

(b) Whether the abortion clinic has engaged in a pattern of noncompliance.

(c) The type, severity and number of violations.

K. The department shall not release personally identifiable patient or physician information.

L. The rules adopted by the director pursuant to this section do not limit the ability of a physician or other health professional to advise a patient on any health issue.

Credits

Added by Laws 1999, Ch. 311, § 2. Amended by Laws 2000, Ch. 365, § 1; Laws 2012, Ch. 250, § 2; Laws 2016, Ch. 75, § 1; Laws 2016, Ch. 267, § 4; Laws 2017, Ch. 133, § 1; Laws 2021, Ch. 286, § 7.

Footnotes

1 Sections 32-1401 et seq., 32-1800 et seq., 32-2901 et seq.

A. R. S. § 36-449.03, AZ ST § 36-449.03

Current through legislation of the First Regular Session of the Fifty-Seventh Legislature (2025), effective as of May 7, 2025.

End of Document

Arizona Administrative Code
Title 9. Health Services
Chapter 10. Department of Health Services Health Care Institutions: Licensing (Refs & Annos)
Article 15. Abortion Clinics (Refs & Annos)

A.A.C. R9-10-1501

R9-10-1501. Definitions

Currentness

In addition to the definitions in A.R.S. §§ 36-401, 36-449.01, 36-449.03, 36-2151, 36-2158, and 36-2301.01 and R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. “Admitting privileges” means permission extended by a hospital to a physician to allow admission of an individual as an inpatient, as defined in R9-10-201:

a. By the patient's own physician, or

b. Through a written agreement between the patient's physician and another physician that states that the other physician has permission to personally admit the patient to a hospital in this state and agrees to do so.

2. “Course” means training or education, including hands-on practice under the supervision of a physician.

3. “Employee” means an individual who receives compensation from a licensee, but does not provide medical services, nursing services, or health-related services.

4. “First trimester” means 1 through 14 weeks as measured from the first day of the last menstrual period or 1 through 12 weeks as measured from the date of fertilization.

5. “Incident” means an abortion-related patient death or serious injury to a patient or fetus delivered alive.

6. “Local” means under the jurisdiction of a city or county in Arizona.

7. “Medical director” means a physician who is responsible for the direction of the medical services, nursing services, and health-related services provided to patients at an abortion clinic.

8. “Medical evaluation” means obtaining a patient's medical history, performing a physical examination of a patient's body, and conducting laboratory tests as provided in R9-10-1509.

9. “Monitor” means to observe and document, continuously or intermittently, the values of certain physiologic variables on a patient such as pulse, blood pressure, oxygen saturation, respiration, and blood loss.

10. “Neonatal resuscitation” means procedures to assist in maintaining the life of a fetus delivered alive, as described in A.R.S. § 36-2301(D)(3).

11. “Patient” means a female receiving medical services, nursing services, or health-related services related to an abortion.

12. “Patient care staff member” means a physician, registered nurse practitioner, nurse, physician assistant, or surgical assistant who provides medical services, nursing services, or health-related services to a patient.

13. “Patient transfer” means relocating a patient requiring medical services from an abortion clinic to another health care institution.

14. “Personally identifiable patient information” means:

a. The name, address, telephone number, e-mail address, Social Security number, and birth date of:

i. The patient,

ii. The patient's representative,

iii. The patient's emergency contact,

iv. The patient's children,

v. The patient's spouse,

vi. The patient's sexual partner, and

vii. Any other individual identified in the patient's medical record other than patient care staff;

b. The patient's place of employment;

c. The patient's referring physician;

d. The patient's insurance carrier or account;

e. Any “individually identifiable health information” as proscribed in 45 CFR 164-514; and

f. Any other information in the patient's medical record that could reasonably lead to the identification of the patient.

15. “Personnel” means patient care staff members, employees, and volunteers.

16. “Serious injury” means a life-threatening physical condition related to an abortion procedure.

17. “Surgical assistant” means an individual who is not licensed as a physician, physician assistant, registered nurse practitioner, or nurse who performs duties as directed by a physician, physician assistant, registered nurse practitioner, or nurse.

18. “Volunteer” means an individual who, without compensation, performs duties as directed by a patient care staff member at an abortion clinic.

Credits

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

Current through rules published in Arizona Administrative Register Volume 31, Issue 19 May 9, 2025. Some sections may be more current. See credits for details.

A.A.C. R9-10-1501, AZ ADC R9-10-1501

End of Document

Arizona Administrative Code
Title 9. Health Services
Chapter 10. Department of Health Services Health Care Institutions: Licensing (Refs & Annos)
Article 15. Abortion Clinics (Refs & Annos)

A.A.C. R9-10-1509
Formerly cited as AZ ADC R9-10-1508

R9-10-1509. Abortion Procedures

Currentness

A. A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:

1. A medical history including:

   a. Allergies to medications, antiseptic solutions, or latex;

   b. Obstetrical and gynecological history;

   c. Past surgeries;

   d. Medication the patient is currently taking; and

   e. Other medical conditions;

2. A physical examination, performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa;

3. The following laboratory tests:

   a. A urine or blood test to determine pregnancy;

   b. Rh typing, unless the patient provides written documentation of blood type acceptable to the physician;

   c. Anemia screening; and

   d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination; and

4. An ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A).

B. If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:

1. The patient receives information from a physician on this condition;

2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;

3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;

4. The form in subsection (B)(3) is maintained in the patient's medical record; and

5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.

C. A physician shall estimate the gestational age of the fetus, based on one of the following criteria, and record the estimated gestational age in the patient's medical record:

1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or

2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.

D. A medical director shall ensure that:

1. The ultrasound of a patient required in subsection (A)(4) is performed by an individual who meets the requirements in R9-10-1506(3);

2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts in a publication distributed nationally that contains peer-reviewed medical information, such as medical information derived from a publication describing research in obstetrics and gynecology or in diagnostic imaging;

3. An original patient ultrasound image is:

a. Interpreted by a physician, and

b. Maintained in the patient's medical record in either electronic or paper form; and

4. If requested by the patient, the ultrasound image is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.

E. A medical director shall ensure that before an abortion is performed on a patient:

1. Written consent, that meets the requirements in A.R.S. § 36-2152 or 36-2153, as applicable, and A.R.S. § 36-2158 is signed and dated by the patient or the patient's representative;

2. Information is provided to the patient on the abortion procedure, including alternatives, risks, and potential complications;

3. Information specified in A.R.S. § 36-2161(A)(12) is requested from the patient; and

4. If applicable, information required in A.R.S. § 36-2161(C) is provided to the patient.

F. A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.

G. A medical director shall ensure that:

1. A patient care staff member monitors a patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;

2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record;

3. If an abortion procedure is performed at or after 20 weeks gestational age, a patient care staff member qualified in neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure takes place before the delivery of the fetus; and

4. If a fetus is delivered alive:

a. Resuscitative measures, including the following, are used to support life:

i. Warming and drying of the fetus,

ii. Clearing secretions from and positioning the airway of the fetus,

iii. Administering oxygen as needed to the fetus, and

iv. Assessing and monitoring the cardiopulmonary status of the fetus;

b. A determination is made of whether the fetus is a viable fetus;

c. A viable fetus is provided treatment to support life;

d. A viable fetus is transferred as required in R9-10-1510; and

e. Resuscitative measures and the transfer, as applicable, are documented.

H. To ensure a patient's health and safety, a medical director shall ensure that following the abortion procedure:

1. A patient's vital signs and bleeding are monitored by:

a. A physician;

b. A physician assistant;

c. A registered nurse practitioner;

d. A nurse; or

e. If a physician is able to provide direct supervision, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, to a medical assistant, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, a medical assistant under the direct supervision of the physician; and

2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner, or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.

I. A medical director shall ensure that follow-up care:

1. For a surgical abortion is offered to a patient that includes:

a. With a patient's consent, a telephone call made to the patient to assess the patient's recovery:

i. By a patient care staff member other than a surgical assistant; and

ii. Within 24 hours after the patient's discharge following a surgical abortion; and

b. A follow-up visit scheduled, if requested, no more than 21 calendar days after the abortion that includes:

i. A physical examination,

ii. A review of all laboratory tests as required in subsection (A)(3), and

iii. A urine pregnancy test;

2. For a medication abortion includes a follow-up visit, scheduled between seven and 21 calendar days after the initial dose of a substance used to induce an abortion, that includes:

a. A urine pregnancy test, and

b. An assessment of the degree of bleeding; and

3. Is documented in the patient's medical record, including:

a. A patient's acceptance or refusal of a follow-up visit following a surgical abortion;

b. If applicable, the results of the follow-up visit; and

c. If applicable, whether the patient consented to a telephone call and, if so, whether the patient care staff member making the telephone call to the patient:

i. Spoke with the patient about the patient's recovery, or

ii. Was unable to speak with the patient.

J. If a continuing pregnancy is suspected as a result of the follow-up visit in subsection (I)(1)(b) or (I)(2), a physician who performs abortions shall be consulted.

Credits

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Former R9-10-1509 renumbered to R9-10-1510; new R9-10-1509 renumbered from R9-10-1508 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018. Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019.

Current through rules published in Arizona Administrative Register Volume 31, Issue 19 May 9, 2025. Some sections may be more current. See credits for details.

A.A.C. R9-10-1509, AZ ADC R9-10-1509

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