

# PHYSICIAN CERTIFICATION FOR AN ABORTION

A COPY OF THIS FORM MUST BE ATTACHED TO EACH INVOICE FOR AN ABORTION SERVICE

All information on this form will be kept strictly confidential.

Date of Service:
Patient Name:
Patient Date of Birth:
Patient’s Address:
Patient’s Insurance ID Number:

**PLEASE COMPLETE EITHER PART I OR PART II:**

**Part I**

I certify, on the basis of my professional judgment, that this patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

\_\_\_\_\_  
(PHYSICIAN’S SIGNATURE)

\_\_\_\_\_  
(DATE)

Physician’s Street Address:

Physician’s Phone Number:

**Part II**

**A MEMBER STATEMENT FORM MUST ACCOMPANY THIS DOCUMENT IF PART II IS COMPLETED.**

This patient is pregnant as a result of:     RAPE     INCEST

I certify that prior to the performance of the abortion, I obtained the attached Member Statement Form signed and dated by the patient.

*Complete the following only if applicable:*

I certify that, on the basis of my professional judgment, this patient was unable to report the incident of:     RAPE     INCEST and/or the identity of the offender because the patient was:     Physically unable or  Psychologically unable.

\_\_\_\_\_  
(PHYSICIAN’S SIGNATURE)

\_\_\_\_\_  
(DATE)

Physician’s Street Address:

Physician’s Phone Number: