

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

**PHYSICIAN CERTIFICATION
FOR AN ABORTION**

*A COPY MUST BE ATTACHED TO
ALL INVOICES FOR ABORTION SERVICES*

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LEAVE THIS SPACE BLANK

3. PATIENT'S NAME:	1. PATIENT'S MA NUMBER
	2. DATE
5. PATIENT'S ADDRESS:	4. PATIENT'S BIRTH DATE:

PLEASE COMPLETE EITHER PART I OR PART II

PART I: LIFE THREAT

I certify, on the basis of my professional judgment, that due to a condition, illness, or injury an abortion is necessary to avert the death of the patient.

6. _____
PHYSICIAN'S SIGNATURE

7. _____
STREET ADDRESS

8. _____
DATE

9. _____
PHONE NUMBER

_____ CITY STATE ZIP CODE

PART II: RAPE OR INCEST – A RECIPIENT STATEMENT FORM MUST BE ATTACHED

10. This patient is the alleged victim of rape or incest.

Check one box below

I certify, on the basis of my professional judgment, that this patient was physically or psychologically unable to report this crime.

This patient certified that she reported the rape or incest to law enforcement authorities or child protective services.

Prior to signing this form, I obtained the attached Recipient Statement Form that is signed and dated by the patient.

11. _____
PHYSICIAN'S SIGNATURE

12. _____
STREET ADDRESS

13. _____
DATE

14. _____
PHONE NUMBER

_____ CITY STATE ZIP CODE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL