



# pennsylvania

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

LEAVE THIS SPACE BLANK

## PHYSICIAN CERTIFICATION FOR AN ABORTION

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

1. PATIENT'S MA NUMBER

2. DATE

3. PATIENT'S NAME:

4. PATIENT'S BIRTH DATE:

5. PATIENT'S ADDRESS:

### PLEASE COMPLETE EITHER PART I OR PART II

#### PART I: LIFE THREAT

I certify, on the basis of my professional judgement 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 judgement, 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**