

**CERTIFICATION FORM FOR INDUCED ABORTION**

I, \_\_\_\_\_, certify that on the basis of  
(Physician's Name)

my professional judgment, the life of \_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_ of \_\_\_\_\_  
(MAID #) (Patient's Address)  
(Please check appropriate box)

Suffered from a \_\_\_\_physical disorder, \_\_\_\_physical injury, and/or \_\_\_\_physical illness that placed her in danger of death if the fetus were carried to term. I further certify that the following procedure(s) were medically necessary to induce an abortion or miscarriage.

(Please indicate date and the procedure that was performed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date