ATTACHMENT VI

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____

Patients' Social Security Number: __ __ __ - __ __ - __ __ __ __

for the following reason:

(CHECK ONE)

( ) There is credible evidence to believe the pregnancy is the result of rape or incest.

( ) The abortion is medically necessary as the woman 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.

SUPPORTING DOCUMENTATION:

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

( ) Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

( ) Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

( ) Medical records documenting the life saving nature of the abortion.

( ) Other (Please Specify): _____

PATIENT ADDRESS:

_____
_____
_____

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____
PHY. NAME: _____
PHY. SS#: __ __ __-__ __-__ __ __ __
PHY. ADD.: _____
_____
_____
_____

THIS FORM MAY BE DUPLICATED