State of Florida
Abortion
Certification Form

SECTION I

1.Recipient's Name:_____

2.Address:_____

3.Medicaid Identification Number:_____

SECTION II

4.On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:

The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.

Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the patient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5._____ 6. _____

Physician's Name Physician's Signature

7._____ 8. _____

Physician's Medicaid Provider Number Date of Signature

August 2001