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