



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