INSTRUCTIONS FOR COMPLETING
"CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"

1. Date of Service: The date the abortion was performed. This can be typed or handwritten.

2. Individual’s Full Name: The name of the individual can be typed or handwritten.

3. Individual’s Date of Birth: Individual’s date of birth can be typed or handwritten.

4. Individual’s Address: Individual’s complete address including street, city, state, and zip code. This can be typed or handwritten.

5. Condition: Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.

6. Supporting Documentation: Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.

7. Physician NPI# and Address: The physician's NPI# and complete address including street, city, state, and zip code. This can be typed or handwritten.

8. Physician Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting after the procedure.

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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:

Individual's Full Name: ____________________________

Individual’s Date of Birth: ____________________________

Individual’s Address: _______________________________
Street Address    City                  State                  Zip Code

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 lifesaving nature of the abortion.

☐ Other (Please Specify): ________________________________

PHYSICIAN PERFORMING ABORTION:
Physician NPI#: ___________________
Physician Address: _________________________________________________
Physician Signature: ___________________ Date: __________________

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