CERTIFICATION FORM FOR INDUCED ABORTION
OR INDUCED MISCARRIAGE

I, _____, certify that on the basis of
(Physician's Name)

my professional judgment, the life of _____
(Patient's Name)

_____ of _____
(MAID #) (Patient's Address)

(Please check appropriate box)

Suffered from a ____physical disorder, ____physical injury, and/or ____physical illness that placed her in danger of death if the fetus were carried to term. I further certify that the following procedure(s) were medically necessary to induce an abortion or miscarriage.

(Please indicate date and the procedure that was performed)

_____

_____

_____

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

MAP-235 (2/00)