



State of Florida Abortion Certification Form

SECTION I

1. Recipient's Name: _____
 2. Address: _____
 3. Medicaid Identification Number: _____
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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. _____
Physician's Name

6. _____
Physician's Signature

7. _____
Physician's Provider Number

8. _____
Date of Signature