State of Florida
Abortion
Certification Form

SECTION I

1. Recipient's Name:_____

2. Address:_____

3. Medicaid Identification Number:_____

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 Medicaid Provider Number

8. _____ Date of Signature

August 2001