**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 judgement, 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 recipient'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