

ABORTION CERTIFICATION FORM

1. I, (Physician) _____, certify that:

2. ___ (1) My patient 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 her in danger unless an abortion is performed; or

___ (2) This pregnancy is a result of sexual assault as defined in W.S. 6-2-301 which was reported to a law enforcement agency within five days after the assault or within five days after the time the victim was capable of reporting the assault; or

___ (3) This pregnancy is the result of a sexual assault as defined in Wyoming Statute W.S. 6-2-301 and the client was unable, for physical or psychological reasons, to comply with the reporting requirements: or

___ (4) The pregnancy is the result of incest.

3. Patient Name: _____

4. Address: _____

5. Physician Signature: _____ Date _____

6. Address: _____
