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) The pregnancy is the result of incest.

3. Patient Name:____

4. Address:____

   ____

5. Physician Signature:____Date_________________

6. Address:____

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