

ABORTION CERTIFICATION FORM

I, Doctor _____, certify that:

- ___ (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.

Patient Name: _____

Address: _____

Physician Signature: _____

Address: _____
