Ohio Department of Job and Family Services
ABORTION CERTIFICATION FORM

I certify that, on the basis of my professional judgment, this service was necessary because (check one box only)

☐ **1** The woman 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, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

☐ **3** The pregnancy was a result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

☐ **4** The pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

☐ **5** The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or

☐ **6** The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

PLEASE NOTE: **The number indicators besides the empty boxes are for departmental use only.**

Patient's Name
Patient's Address
City, State, and Zip Code
Patient's Medicaid Billing Number

Physician's Name (Please Type)	
Physician's Medicaid Provider Number	
Physician's Signature	Date

OAC 5101:3-17-01 required completion of this form in order to receive Medicaid reimbursement.

JFS 03197 (Rev. 3/2005)