W-484
(Rev. 6/94)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

PHYSICIAN'S CERTIFICATION FOR ABORTION (TITLE XIX)

I hereby certify that ① _____
NAME OF PATIENT

② _____ has requested
ADDRESS

performance of an abortion. On the basis of my professional judgment, I certify that this abortion is necessary because:

③ ☐ life of the mother would be endangered if the fetus were carried to term; or,

☐ pregnancy is due to rape; or,

☐ pregnancy is due to incest.

My reason for having made the above determination is based on ④ _____

_____

The abortion will be performed at ⑤ _____
HOSPITAL OR LICENSED CLINIC

on ⑥ _____.
DATE

⑦ _____
Signature of Attending Physician

⑧ _____
Date