ATTESTATION OF COMPLIANCE WITH A.R.S. 35-196.05

On behalf of the Provider identified below my signature, I hereby attest to the following:

1. As of August 2, 2012, and thereafter, the Provider will not perform any abortions for any member of the public or maintain or operate a facility where any abortion is performed for any member of the public unless one of the following conditions is present:
    a. A licensed physician has certified that the pregnant 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 places the member in danger of death unless the pregnancy is terminated.
    b. The pregnancy is a result of rape or incest.
    c. A licensed physician has attested that the pregnancy termination is medically necessary for an AHCCCS eligible woman because continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant woman by:
        i. Creating a serious physical or mental health problem for the pregnant member,
        ii. Seriously impairing a bodily function of the pregnant member,
        iii. Causing dysfunction of a bodily organ or part of the pregnant member,
        iv. Exacerbating a health problem of the pregnant member, or
        v. Preventing the pregnant member from obtaining treatment for a health problem.
    d. Other circumstances where, under A.R.S. 35-196.05(B), a medical condition exists such that the abortion is performed for a treatment of a medical condition and is not performed for the provision of family planning services. Describe the circumstances and medical condition here: _____
    _____
    _____

2. The Provider will inform the AHCCCS Administration within 48 hours if the Provider fails to comply at any time with these attestations by providing written notice sent to:

    AHCCCS Provider Registration
    P.O. Box 25520, Mail Drop 8100
    Phoenix, AZ 85002

3. I am authorized to make these attestations on behalf of the Provider.

Signature	Date
Printed Name	Provider Name
Title	Provider ID number