FORM I

[See Regulation 3]

Name and qualifications of the Registered Medical practitioner in block letters

_____

Full address of the Registered Medical Practitioner

_____

Name and qualifications of the Registered Medical Practitioner in block letters

_____

Full address of the Registered Medical Practitioner hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of _____

_____

Full name of pregnant women in block letters _____

Resident of _____

Full address of pregnant women in block letters

For the reasons given below*.

I/We hereby give intimation that I/we terminated the pregnancy of the woman referred to above who bears the Serial No._____ in the admission register of the hospital/approval place.

Place: Signature of Registered Medical Practitioner

Date:

Signature of Registered Medical Practitioner

*Strike out whichever is not applicable
**of the reasons specified item (i) to (v) write the one which is appropriate.

(i) In Order to save life of the pregnant women
(ii) In order to prevent grave injury to the physical and mental health of the pregnant women
(iii) In view of substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped
(iv) As pregnancy is alleged by pregnant women to have been caused by rape
(v) As the pregnancy has occurred as a result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children

Note: Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place Signature of Registered Medical Practitioner

FORM C

(See rule 9)

I _____ daughter / wife of _____ aged about _____ years at present residing at _____ (state the permanent address) do hereby give my consent to termination of my pregnancy at _____ (state the name of place where pregnancy is to be terminated)

_____ _____ _____

Place Date Signature / Thumb impression

(To be filled in by guardian where the woman is mentally ill person or minor)

I _____ son / daughter / wife of_____ aged about _____ years at present residing at (Permanent address) _____ do hereby give my consent to the termination of the pregnancy of my ward _____ who is a minor / mentally ill person at _____(place of termination of pregnancy)

_____ _____ _____

Place Date Signature / Thumb impression

FORM F

1. Government/Non-Government**……..**
2. Residence of the patient □ Urban □ Rural
3. Patient Age**……..**
4. Total monthly income of the patient's family**……..**
5. Education of the patient**……..**
6. Education of the husband……
7. Occupation of (a) Patient **……** (b) Husband **……**
8. Religion □ Hindu □ Muslim □ Christian □ Others (specify)……
9. Marital Status □ Single □ Married □ Widowed □ Divorced or separated
10. Date of last menstrual period……..
11. Previous pregnancies Live births □ Male □ Female
    Still births □ Male □ Female
    Abortions □ Induced □ Spontaneous
12. Date of last termination of pregnancy under the act …….
13. Number of existing children …….
14. Last contraceptive method used (in case of termination due to failure of any device or method)
    □ Tubal Ligation □ Vasectomy □ I.U.C.D □ Conventional Contraceptive □ Others
15. Date of admission to place of termination……..