Pennsylvania Insurance Department **Children's Health Insurance Program**

MEMBER STATEMENT FORM

A COPY OF THIS FORM MUST BE ATTACHED TO EACH PHYSICIAN CERTIFICATION FOR AN ABORTION FORM THAT ATTESTS THE MEMBER WAS PREGNANT AS A RESULT OF RAPE OR INCEST

All information on this form will be kept strictly confidential.

Patient Name:
Patient Date of Birth:
Patient's Address:
Patient's Insurance ID Number:
Type of Incident: ☐ RAPE ☐ INCEST
Date of Incident:
PLEASE COMPLETE EITHER PART I OR PART II AND THEN SIGN AND DATE BELOW
Part I: ☐ I certify that I was the victim of the above-named incident and that I reported it to the following law Enforcement or county child protective service agency: _____
Date of Report: _____
My Report ☐ Did ☐ Did Not Include the identity of the offender.
I ☐ Do ☐ Do Not Know the identity of the offender.
Part II: ☐ I certify that I was the victim of the above-named incident and that I did **not** report the crime.
I understand that any false statements made herein are punishable by law and that false reports to law enforcement authorities are punishable by law.
_____ _____ (Signature of Victim) (Date)