**RMP OPINION FORM**

# FORM I

I_____

(Name and qualifications of the Registered Medical practitioner in block letters)

_____

(Full address of the Registered Medical practitioner)

I_____

(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/approved place.

Signature of the registered Medical Practitioner

Signature of the registered Medical Practitioners

Place :
Date :

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

(i) in order to save the 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 the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,

(iv) as the pregnancy is alleged by pregnant women to have been caused by rape,

(v) as the pregnancy has occurred as 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 women'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 :
Date :

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners