PREGNACY Verification for

Out-of Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Woman's Name)

(born _____), whom I saw on _____ is pregnant.
(Woman's Date of Birth) (PRINT: Visit Date)

_____ _____
HEALTH CARE PROVIDER'S SIGNATURE DATE

_____
HEALTH CARE PROVIDER'S LICENSE NUMBER

INFANT Verification for

Out –of-Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Infant's Name)

Was born alive on _____ to _____
(Infant's date of birth) (PRINT: Mother's Name)

_____ _____
HEALTH CARE PROVIDER'S SIGNATURE DATE

_____
HEALTH CARE PROVIDER'S LICENSE NUMBER

Revised: 01/16/2013