**State of Alaska**
**Department of Health & Social Services**
**Division of Public Assistance**

# Pregnancy Verification Form

**You may use this form or another statement signed by your medical provider to verify pregnancy.**

Patient Name: _____ Date of Birth_____
(Please print)

I certify that the above named individual is pregnant and that the following information is accurate:

Estimated Delivery Date (EDD): _____

Are multiple births expected? _____

If yes, how many? _____

Health Care Provider Signature: _____ _____
(Doctor, Nurse, Medical Practitioner, etc.) Date

Health Care Provider Name: _____ _____
(Please print) Phone

Health Care Provider Title: _____

**Health Care Provider: Please complete this form and return it to your patient, or send the completed form to:**

| | | | | |
|---|---|---|---|---|
| Name: | Division of Public Assistance | | | |
| Address: | | | | |
| City: | | State: | Alaska | Zip: |
| Fax: | | | | |

Save As Print Clear Form