PREGNANCY 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