Verification of Birth from Hospital

Personal Information

- **Full Name of Newborn: _____**
- **Date of Birth (MM/DD/YYYY): _____**
- **Time of Birth: _____**
- **Gender: ☐ Male ☐ Female**
- **Mother's Full Name: _____**
- **Father's Full Name: _____**
- **Place of Birth (Hospital Name): _____**
- **Address of Hospital: _____**

Hospital Verification Details

- **Attending Doctor's Name: _____**
- **Contact Number: _____**
- **Hospital Registration Number: _____**
- **Delivery Method: ☐ Natural ☐ C-Section**
- **Weight of Baby at Birth: _____ lbs/kg**
- **Length of Baby: _____ inches/cm**

Certification Statement

I, _____, confirm that the above information is accurate as per hospital records.

Authorized Hospital Staff Signature: _____

Date: _____

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Verified By	Date Verified	Comments	Approved ☐ / Rejected ☐

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