PREGNANCY Verification for
Out-of-Institution Births
(This can be used for the Section 1 documentation requirement)

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
(This can be used for the Section 2 documentation requirement)

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