

## **PREGNANCY VERIFICATION FOR OUT-OF-INSTITUTE BIRTHS**

Patient's Name:	
Patient's DOB:	
Date of Exam Visit: <i>(Office and/or Home)</i>	
Health Care Provider's Printed Name:	
Health Care Provider's Signature and Title:	
Date:	
Health Care Provider's License Number:	

## **LIVE BIRTH VERIFICATION FOR OUT-OF-INSTITUTE BIRTHS**

Infant's Name:	
Infant's DOB:	
Date of Exam Visit: <i>(Office and/or Home)</i>	
Health Care Provider's Printed Name:	
Health Care Provider's Signature and Title:	
Date:	
Health Care Provider's License Number:	