

**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 recipient, or send the completed form to:

Name: Division of Public Assistance

Address: _____

City: _____ State: Alaska Zip: _____

Fax: _____