STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

PREGNANCY VERIFICATION

THIS IS TO VERIFY THAT ____
(Please print patient's name)

IS PREGNANT WITH AN ESTIMATED DELIVERY DATE OF__________________.

MEDICAL PROVIDER SIGNATURE: ____________________________
(Doctor, Nurse, Medical Practitioner, etc.)

PRINTED NAME: ____

TITLE: ____

DATE: ____

TO MEDICAL PROVIDER: PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR PATIENT, OR SEND THE COMPLETED FORM TO THE DIVISION OF PUBLIC ASSISTANCE OFFICE.