PREGNANCY VERIFICATION

COUNTY OF

Notice Date : _____
Case Name : _____
Case Number : _____
Worker Name : _____
Worker Number : _____
Telephone Number: _____
Address : _____
_____
_____

(Addressee)

I hereby authorize the physician or authorized medical provider below to release to the County of _____ the specific information requested below:
(County Name)

Signature: _____ Date _____

Name of Medical Provider or Physician: _____

Address of Provider Offices:

_____

_____

Provider's Telephone Number: _____

Provider's Fax Number: _____

TO BE COMPLETED BY EXAMINING PHYSICIAN OR AUTHORIZED MEDICAL PERSONNEL

Please verify pregnancy and specify this person's "expected" or estimated date of delivery.

Pregnant: ☐ Yes ☐ No	Expected Delivery Date:

_____ _____
Signature of Physician or Authorized Medical Personnel: (Date)