

Proof of Pregnancy

Patient's Name:

Age:

Phone Number:

Date of Birth:

Address:

Email:

Last Menstrual Period:

Expected Delivery Date:

Age of Gestation (Weeks):

Number of Fetuses:

Mother's Medical Condition:

Medical Condition of the Baby:

I, _____, as a gynecologist, hereby confirm that _____ has been under my medical care and supervision for her pregnancy and affirm that the information stated above is true and correct. I have clinically confirmed that as of the date of this Proof of Pregnancy, the Patient is pregnant and her pregnancy has been stable. This statement is provided upon the patient's request to verify her pregnancy and I understand that any misrepresentation, false information, or misleading information can be charged with a criminal act punishable by law and subject to any civil penalties.

OB/Gyne

Name:

Date:

Date Signed:

Hospital/Clinic Address: