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.