**Section 1: Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Date of Birth: |  |
| Contact Number: |  | Email Address: |  |

**Section 2: Medical Specialist Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Specialist’s Name: |  | Specialty: |  |
| Medical License Number: |  | Contact Number: |  |
| Office Address: | Street Address: City, State, ZIP Code. | | |

**Section 3: Pregnancy Verification**

I, the undersigned medical specialist, hereby verify that the above-named patient is pregnant.

|  |  |  |  |
| --- | --- | --- | --- |
| Date Pregnancy Confirmed: |  | Expected Due Date: |  |
| Gestational Age at the Time of Verification (in weeks): | | |  |

**Section 4: Medical Specialist’s Certification**

I certify that the information provided above is accurate and based on my medical examination and/or tests.

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Specialist’s Signature: | Signature | Date: |  |
| Medical Specialist’s Printed Name: | |  | |

**Section 5: Patient Authorization**

I authorize my medical specialist to release the above information to my employer for the purpose of verifying my pregnancy and determining eligibility for any applicable benefits and accommodations.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Signature: | Signature | Date: |  |

**Section 6: For Office Use Only (Employer)**

|  |  |  |  |
| --- | --- | --- | --- |
| Received By: |  | Date: | (DD/MM/YYYY) |
| Processed By: |  | Date: | (DD/MM/YYYY) |
| Approved By: |  | Date: | (DD/MM/YYYY) |

**Section 7: Comments**

**Additional Comments:**

|  |
| --- |
|  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **HR Signature:** | Signature | **Date:** | (DD/MM/YYYY) |