

PREGNANCY VERIFICATION LETTER

_____ [Healthcare Provider/Pregnant Individual Name]
_____ [Healthcare Provider/Pregnant Individual Address]
_____ [Healthcare Provider/Pregnant Individual Phone]
_____ [Healthcare Provider/Pregnant Individual Email]

_____ [Date]

_____ [Requesting Party Name/Entity Name]
_____ [Requesting Party Address]
_____ [Requesting Party Phone]
_____ [Requesting Party Email]

Dear _____ [Requesting Party Name/Entity Name],

This letter is to certify that _____ [Pregnant Individual Name], with date of birth _____ [Date of Birth], is under care at _____ [Healthcare Provider Name]. After conducting the necessary medical examinations, I we can confirm that I am she is pregnant.

Pregnancy Information:

Estimate Date of Conception: _____
Expected Due Date: _____

(Optional, if any)

Medical Condition:

Medical Complication:

Care/Medication Received:

Physician Information:

Physician Name: _____

Physician Title: _____

Contact Number: _____

Contact Email: _____



Physician Signature: _____

Please note that pregnancy is a natural condition and the estimated due date is subject to change based on the progression of the pregnancy and the results of subsequent medical assessments.

If any additional information is required or there are specific forms that need completion related to this pregnancy verification, please contact my physician or healthcare provider directly..

Thank you for your attention to this matter.

Sincerely,

_____ [Healthcare Provider/Pregnant Individual Name]

