NORTH CAROLINA
_____COUNTY DEPARTMENT OF SOCIAL SERVICES
Verification of Pregnancy

DATE _____

Dear Medical Provider:

The individual named below has applied for assistance for pregnant women. Please help us by completing the following information:

_____ is approximately _____ weeks pregnant.
name

Projected due date (EDC) is _____
day/month/year

Number of children expected _____

Name of medical professional: _____

*Signature of medical professional: _____ Date: _____

Name of practice or facility:
_____

Address of practice or facility:
_____

_____

Practice or facility phone number: _____

*Must be signed by a MD, PA, Nurse Practitioner, RN or LPN