VERIFICATION OF PREGNANCY AND GESTATIONAL AGE
By Local Health Department
Michigan Department of Community Health

I certify that on _____________ (date) at ________________ (time) at the
________________ health department, the pregnancy of
________________________ (patient) was confirmed.

At this time, the gestational age of the fetus is ____________________.

____________________________________                       ____________
Signature of Local Health Department Official                         Date Signed

Authority:  PA 345 of 2000

Completion: IS REQUIRED, if the patient requests a pregnancy verification and
determination of gestational age in order to fulfill the requirements of the

Copy Distribution:  Patient
                     Local Health Department