



CONFIRMATION OF STILL BIRTH

To be completed by the Doctor at the hospital of birth

POLICY INFORMATION

Membership No: Main Member ID Number:.....

Name: Surname:

DETAILS OF CHILD

Name and Surname of Child/Still born:

Date of birth: Place of birth:

Birth weight: Pregnancy period:

Cause of death:

DETAILS OF MOTHER

Name: Surname:

Mother ID Number:

Address:

.....

HOSPITAL CONFIRMATION

Signed at: Date:

Name of Doctor: Surname of Doctor:

Designation: Contact number:

Official stamp

