Confirmation of the Type of Childbirth Delivery for Indiana State Employees

Patient's Full Name: _____

Date of Delivery: _____

Please circle one
Type of Delivery: VAGINAL C-SECTION

Additional Comments, if any: _____
_____

Medical Doctor or Midwife must sign-off on this information.

Printed Name_____

Signature_____

Telephone Number: _____

Fax Number: _____

Business Address: _____

_____

Date: _____

Completed form should be faxed to 317.974-2029, Indiana State Personnel Department.