

**MEDICAL CERTIFICATE FROM DOCTOR OR REGISTERED MIDWIFE
authorising the cremation or burial of fetal remains
of less than 24 weeks' gestation**

I hereby certify that I have examined the fetal remains of:

Address

Delivered on _____ at _____

at _____ weeks' gestation _____

and at no time after birth showed any visible signs of life.

I know of no reason why any further enquiry or examination should be made.

Name _____

Signature _____

Registered qualifications _____

Address _____

Telephone number _____

Date _____