

**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:**

[Mother's name or case number] \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Delivered on [date] \_\_\_\_\_ at [time] \_\_\_\_\_

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 \_\_\_\_\_