Form A006
V1.1 Rel. 20161101

National Fund for Municipal Workers

Stillborn: Hospital Confirmation

PARTICULARS OF HOSPITAL	
Name of hospital	
Name of person completing form (Matron or Superintendent)	
Capacity	
Contact number	

PARTICULARS OF DECEASED	
Name of deceased	
Date of birth	D D M M Y Y Y Y
Date of death	D D M M Y Y Y Y
Number of weeks of pregnancy	
Name of mother	
ID No. of mother	
Name of father	
ID No. of father	

We certify above information to be correct.

Official Stamp of Hospital

_____
Signature: Matron / Superintendent

D D M M Y Y Y Y
Date

_____
Signature: Mother of deceased

D D M M Y Y Y Y
Date

_____
Signature: Father of deceased

D D M M Y Y Y Y
Date

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