

# Health Facility Birth Certificate

## Blank Format

Name of Facility

---

Facility Address

---

Certificate No.

---

This is to certify that

---

(Full name of child)

was born on

---

(Date of Birth)

at

---

(Time of Birth)

Sex

---

Weight at Birth

---

Length at Birth

---

to

---

(Mother's Name)

and

---

(Father's Name)

Attending Physician/Midwife

---

(Name & Qualification)

Signature

\_\_\_\_\_

Date Issued

\_\_\_\_\_

Facility Stamp/Seal

\_\_\_\_\_