

**THE VIRGINIA BIRTH-RELATED NEUROLOGICAL  
INJURY COMPENSATION PROGRAM**

**VERIFICATION FORM**

**PATIENT** \_\_\_\_\_  
PRINT CHILD'S NAME

**WAS SEEN AT THIS FACILITY**

\_\_\_\_\_  
NAME OF DOCTOR'S OFFICE, HOSPITAL OR OTHER

**ON** \_\_\_\_\_  
DATE OF APPOINTMENT

**BY** \_\_\_\_\_  
NAME OF DOCTOR, THERAPIST, NURSE PRACTITIONER, OTHER

**SIGNED** \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE

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