The National Insurance Board
Of the Commonwealth of The Bahamas
The National Insurance Act, 1972

For NIB Use Only
Registration Form (DP-1) received? ☐Yes ☐No
Receiving Officer _____

NATIONAL PRESCRIPTION DRUG PLAN
ANTE-NATAL/POST-NATAL CERTIFICATE

Section A: Claimant Details *(To be completed by claimant)*

1. ☐ Mrs. ☐ Ms. _____
   Last Name *First Name* *Middle Name(s)*
2. N.I.#: _____ 3. Date of Birth: _____
   dd/mm/yyyy
4. Address: _____
5. City/Settlement: _____ 6. Island: _____
7. Telephone #1: _____ 8. Telephone #2: _____
9. P.O. Box: _____ 10. Email Address: _____

Section B: Confinement Details *(To be completed by physician)*

11. Is claimant pregnant at this time? ☐ Yes ☐ No
    a) If yes, please indicate expected date of delivery. _____
       *Comments, if necessary:*_____
    b) If no, please indicate actual date of delivery. _____
       *Comments, if necessary:*_____
12. Physician's Signature: _____ _____
    Name (please print) *Signature*
13. Medical Registration #: _____ 14. Date form completed by physician: _____
    dd/mm/yyyy

Please affix physician stamp in the box at left.

Section C: Claimant's Declaration

I certify that the information contained in this form is true and correct to the best of my knowledge and belief. I undertake that if this benefit is awarded I shall inform the National Prescription Drug Plan Office of any change in my condition, which may affect my entitlement to this Benefit.

14. Claimant's Signature: _____
15. Date: _____
    dd/mm/yyyy

IMPORTANT NOTE

This form MUST be accompanied by a National Prescription Drug Plan Registration Form. (Form DP-1).