



OREGON  
**HEALTH**  
AUTHORITY

# Birth Information Specialist and Midwife Training 2025

# Training Requirement

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- ❑ This training is required to file Oregon birth records and to use the Oregon Vital Events Registration System (OVERS).
- ❑ If you are a new Birth Information Specialist (BIS) or Midwife needing to file Oregon birth records and use OVERS, this training must be completed before you can get a login and password to OVERS.
- ❑ Certificates of completion must be provided.

# Agenda

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- ❑ Laws, Policies & Procedures
- ❑ An introduction to the worksheets
- ❑ A link to a demonstration of OVERS entry
- ❑ Birth Information Specialist training from CDC Train
- ❑ What is needed for an OVERS account
- ❑ Resources and Contacts

# The work you do is of **VITAL** importance

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## **For the individual:**

The birth certificate is the most important document used to establish an individual's identity.

## **For the family:**

It allows the parents to establish the child's identity and claim a range of benefits like tax credits and health care.

## **For public health partners:**

It helps identify trends and indicators of health, which can assist in policy development, funding and research.

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# **Laws, policies and procedures**

# Highlights of the laws and policies

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- ❑ All births that occur in Oregon must be filed with the state.
- ❑ Each birth must be submitted to the state within 5 calendar days after the live birth.
- ❑ The hospital or licensed birthing facility where the birth occurred is responsible for filing the birth record with the state.
- ❑ Births that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.

# Highlights of the laws and policies

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- ❑ The hospital or licensed birthing facility must make voluntary acknowledgment of paternity forms available to unmarried parents.
- ❑ Once filed and registered with the state, the birth record becomes the permanent record of the birth.
- ❑ Any changes to the birth record after it is registered must be done through an official amendment process and the change becomes permanent.

# Oregon Revised Statutes Chapter 432

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## **432.088 Mandatory submission and registration of reports of live birth; persons required to report; rules.**

(1) A report of live birth for each live birth that occurs in this state shall be submitted to the Center for Health Statistics, or as otherwise directed by the State Registrar of the Center for Health Statistics, within five calendar days after the live birth and shall be registered if the report has been completed and filed in accordance with this section.



# Oregon Revised Statutes Chapter 432

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**ORS 432.093 Availability of voluntary acknowledgment of paternity form; responsibility of health care facility and parents.** Any health care facility as defined in ORS 442.015 shall make available to the biological parents of any child born live or expected to be born in the health care facility, a voluntary acknowledgment of paternity form when the facility has reason to believe that the mother of the child is unmarried. The responsibility of the health care facility is limited to providing the form and submitting the form with the report of live birth to the State Registrar of the Center for Health Statistics. The biological parents are responsible for ensuring that the form is accurately completed. This form shall be as prescribed by ORS 432.098. [Formerly 432.285]

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***In 2023,  
38,295  
births  
occurred  
in Oregon***



**99%**

of birth records are electronically registered at medical facilities and birthing centers.

# How are birth records completed?

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1. Birth Information Specialists or Midwives gather information from parents and medical record.
2. Information is entered into OVERS.
3. The birth records will automatically register and become the official birth record once it is certified by the Birth Information Specialist or Midwife.

**All within  
5 days**



# Worksheets

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- ❑ There are two worksheets used to collect the information for the completing the birth record.
  1. Parent worksheet
  2. Facility worksheet
- ❑ The worksheets are standardized so that all information is collected the same way for all births in Oregon.
- ❑ The worksheets provided or approved by the Center for Health Statistics must be used to collect the information.
- ❑ Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

# Parent Worksheet

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Completed by the parent(s)

This is where the parents name the baby and provide information for their baby's legal birth certificate.

Please remind parents to:

- Read the cover sheet carefully.
- Write clearly and review the information.
- Provide precise and correct information.
- Answer every question as much as possible, even if the answer is "don't want to answer."
- Sign the worksheet.

# Parent Worksheet

**Oregon Health**  
Center for Health Statistics

**Birth Record**  
**PARENT WORKSHEET**

Please print neatly

Page 1 of 5

**CHILD**

1. Legal Name as you want it to appear on the birth certificate

First Middle Other Middle Last Suffix

2. Date of Birth MM / DD / YYYY

3. Sex ☐ Female ☐ Male ☐ Undetermined ☐ X

4. Do you want to request a social security number for the child?  
☐ Yes ☐ No (If Yes, complete attached authorization to establish social security number at birth.)

**BIRTH MOTHER (THE PERSON WHO HAD THE BABY)**

5. Your Current Legal Name

First Middle Last Suffix

6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth ☐ Check if same as Current Legal Name

First Middle Last Suffix

7. Date of Birth MM / DD / YYYY

8. Social Security Number ☐ Check if none

9. Birthplace State Country

**BIRTH MOTHER'S ADDRESS**

10. Mother's Residence Address

No. & Street Apt./Unit/Space City County State ZIP

11. Mother's Mailing Address (if different)

☐ Same as residence No. & Street or PO Box Apt./Unit/Space City County State ZIP

12. Residence Inside City Limits? ☐ Yes ☐ No

13. Primary Telephone Number

14. Secondary Telephone Number

**BIRTH MOTHER DEMOGRAPHICS**

15. Education: What is the highest level of education you have completed?

☐ 8th grade or less ☐ Some college credit but no degree ☐ Master's degree

☐ 9th - 12th grade; no diploma ☐ Associate's degree ☐ Doctorate or Professional degree

☐ High school diploma or GED ☐ Bachelor's degree

Race or Ethnicity: Complete BOTH questions (16 and 17)

16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?  
Write your answer here: \_\_\_\_\_

17a. Which of the following describes your racial or ethnic identity? Please check ALL that apply.  
If you select Other or American Indian and Alaskan Native, please provide additional information in the space provided for Specify or Specify Tribe(s).

**Hispanic and Latino/a:**

☐ Central American

☐ Mexican

☐ South American

☐ Cuban

☐ Puerto Rican

☐ Other Hispanic or Latino/a

Specify \_\_\_\_\_

**Native Hawaiian and Pacific Islander:**

☐ Chamorro (Chamorro)

☐ Marshallese

☐ Communities of the Micronesian Region

☐ Native Hawaiian

☐ Samoan

☐ Other Pacific Islander

Specify \_\_\_\_\_

**White:**

☐ Eastern European

☐ Slavic

☐ Western European

☐ Other White

Specify \_\_\_\_\_

**American Indian and Alaska Native:**

☐ American Indian

☐ Alaska Native

☐ Canadian-Inuit, Metis, or First Nation

☐ Indigenous Mexican, Central American, or South American

Specify Tribe(s) \_\_\_\_\_

**Black and African American:**

☐ African American

☐ Afro-Caribbean

☐ Ethiopian

☐ Somali

☐ Other African (Black)

Specify \_\_\_\_\_

☐ Other Black

Specify \_\_\_\_\_

**Middle Eastern/North African:**

☐ Middle Eastern

☐ North Africa

**Asian:**

☐ Asian Indian

☐ Cambodian

☐ Chinese

☐ Communities of Myanmar

☐ Filipino

☐ Hmong

☐ Japanese

☐ Korean

☐ Ladinian

☐ South Asian

☐ Vietnamese

☐ Other Asian

Specify \_\_\_\_\_

☐ Not listed please specify: \_\_\_\_\_

**Opt out options:**

☐ Don't know

☐ Don't want to answer

Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

- Baby's information
- Parents' address and demographics
- Legal relationship of parents
- Mother's health
- Prenatal information
- Social Security Number authorization

# Facility Worksheet

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- Completed by the BIS or designee. The process for gathering the information may vary among hospitals or birthing facilities.
- Usually from medical record or provided by labor and delivery nurses at time of birth.
- You must use the facility worksheet provided or approved by the Center for Health Statistics.
- Parents do not see this worksheet.
- Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

# Facility Worksheet

- Medical and health information for the mother
- Prenatal information
- Pregnancy factors
- Labor and delivery information
- Newborn factors
- Hearing screening
- Immunization

**IMPORTANT:**  
The worksheet is designed to flow  
with OVERS data entry

**Oregon Health**  
Center for Health Statistics

**Birth Record**  
FACILITY WORKSHEET

Please print neatly

(Page 1 of 2)

**CHILD**  
Name: First, Middle, Last, Suffix  
Date of Birth: MM/DD/YYYY  
Time of Birth: AM, PM, Military  
Sex: Female, Male, Undetermined, X

**MOTHER HEALTH**  
Did Mother get WIC food for herself during pregnancy? Yes, No, Unknown  
Cigarette Smoking: Check if none, Number per day, 3 months before pregnancy, 1st 3 months of pregnancy, 2nd 3 months of pregnancy, 3rd 3 months of pregnancy  
Height: ft, in  
Weight (Pre-pregnancy): lbs  
Weight (At delivery): lbs  
Alcohol use during this pregnancy? Yes, No, If yes, average number of drinks per week?

**PLACE OF BIRTH**  
At this facility, Home delivery, Was home delivery planned? Yes, No, Unknown  
Other location (specify):  
Specify address if not this facility: No. & Street, Apt/Unit/Space, City, County, State, ZIP

**PRENATAL**  
Mother's Medical Record # (optional):  
Mother's Medicaid #:   
Date of Last Menses (date of last period): MM/DD/YYYY  
Prenatal Care: Check if none, Date of 1st visit: MM/DD/YYYY, Total # of visits:   
Previous Live Births: # now living, # now dead, Date of last live birth: MM/YYYY  
Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy):  
Combined # of other outcomes: , Date of last other outcome: MM/YYYY  
Mother tested for HIV? Yes, No, Unknown

**PREGNANCY FACTORS**  
Risk Factors: Diabetes - Gestational, Diabetes - Pre-pregnancy, Hypertension - Pre-pregnancy (Chronic), Hypertension - Gestational, Hypertension - Eclampsia, Previous Preterm Births (<37 Completed Wks. Gestation), Pregnancy Resulted From Infertility Treatment - Fertility-enhancing drugs, Pregnancy Resulted From Infertility Treatment - Assisted Reproductive Technology, Mother Had A Previous Cesarean Delivery, How Many?, None Of The Above  
Mother tested for: Syphilis, Group B Strep, Gonorrhea, Syphilis, Hepatitis B, Hepatitis C, Chlamydia, None of the above  
Obstetric Procedures: External cephalic version: Successful, Failed

**LABOR**  
Characteristics of Labor and Delivery: Induction of labor, Augmentation of labor, Steroids for fetal lung maturation prior to delivery, Antibiotics during labor, Clinical chorioamnionitis diagnosed during labor or maternal temp. >= 38C, Epidural or spinal anesthesia during labor, Unknown, None of the above

**DELIVERY**  
Method of Delivery: Cephatic, Breech, Other, Unknown  
Fetal Presentation at Delivery: Cephatic, Breech, Other, Unknown  
Final Route and Method of Delivery: Vaginal/Spontaneous, Vaginal/Forceps, Vaginal/Vacuum, Cesarean, Unknown  
If Cesarean, was a Trial of Labor Attempted? Yes, No  
Maternal Morbidity (check all that apply): Maternal transfusion, Third or fourth degree perineal laceration, Ruptured uterus, Unplanned hysterectomy, Admission to intensive care unit, None of the above, Unknown at this time  
Mother transferred to this facility prior to delivery? Yes, No, If yes, name of facility:   
Infant transferred from this facility after delivery? Yes, No, If yes, name of facility:

**Hospital Staff**  
Last revised: March 2018  
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.



# Recap Parent and Facility Worksheets

**Oregon Health**  
Center for Health Statistics

**Birth Record PARENT WORKSHEET** (Page 1 of 2)

Please print neatly

**CHILD**  
Legal Name as you want it to appear on the birth certificate  
First Middle Other Middle Last Suffix

Date of Birth: MM/DD/YYYY  
Sex: ☐ Female ☐ Male ☐ Undetermined ☐ X  
Do you want to request a social security number for the child? (complete attached authorization to establish social security number at birth)  
☐ Yes ☐ No

**BIRTH MOTHER (THE PERSON WHO HAD THE BABY)**  
Your Current Legal Name  
First Middle Last Suffix

Your Legal Name prior to first marriage/Your Legal Name at Birth ☐ Check if same as Current Legal Name  
First Middle Last Suffix

Date of Birth: MM/DD/YYYY  
Social Security Number ☐ Check if none  
Birthplace: State COUNTRY

**BIRTH MOTHER'S ADDRESS**  
Mother's Residence Address: No. & Street Apt/Unit/Space City County State ZIP

Mother's Mailing Address (if different): No. & Street or PO Box Apt/Unit/Space City County State ZIP  
☐ Same as residence

Residence Inside City Limits? ☐ Yes ☐ No  
Primary Telephone Number Secondary Telephone Number

☐ Chinese ☐ Native Hawaiian ☐ Unknown  
☐ Filipino

**BIRTH MOTHER'S HEALTH**  
Did you get WIC food for yourself during pregnancy? ☐ Yes ☐ No  
Height: ft. in. Weight (Pre-pregnancy): lbs. Weight (At delivery): lbs.  
Cigarettes Smoked Per Day: 3 months before pregnancy # Cigarettes 1st 3 months of pregnancy # Cigarettes 2nd 3 months of pregnancy # Cigarettes 3rd 3 months of pregnancy # Cigarettes  
Did you drink alcohol during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?  
Did you go into labor planning to deliver at home or at a freestanding birthing center (excludes hospital birthing center)?  
☐ Yes ☐ No  
If yes, the planned primary attendant type at onset to labor was:  
☐ Traditional Midwife ☐ Certified Nurse Midwife  
☐ Naturopathic Doctor ☐ Medical Doctor  
☐ Licensed Direct Entry Midwife

Hospital Staff  
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

OHA 9704 (03/18)

## 1) Parent Worksheet: Completed by the parent(s)

**Oregon Health**  
Center for Health Statistics

**Birth Record FACILITY WORKSHEET** (Page 1 of 2)

Please print neatly

**CHILD**  
Name: First Middle Last Suffix

Date of Birth: MM/DD/YYYY  
Time of Birth: ☐ AM ☐ PM ☐ Military  
Sex: ☐ Female ☐ Male ☐ Undetermined ☐ X

**MOTHER HEALTH**  
Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown  
Cigarette Smoking: ☐ Check if none  
Number per day: 3 months before pregnancy # Cigarettes 1st 3 months of pregnancy # Cigarettes 2nd 3 months of pregnancy # Cigarettes 3rd 3 months of pregnancy # Cigarettes  
Height: ft. in. Weight (Pre-pregnancy): lbs. Weight (At delivery): lbs.  
Alcohol use during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?

**PLACE OF BIRTH**  
☐ At this facility ☐ Home delivery Was home delivery planned? ☐ Yes ☐ No ☐ Unknown  
☐ Other location (specify):  
Specify address if not this facility: No. & Street Apt/Unit/Space City County State ZIP

**PRENATAL**  
Mother's Medical Record # (optional):  
Mother's Medicaid #: ☐ Medicaid/Oregon Health Plan ☐ Private insurance ☐ Self-pay ☐ Indian Health Services  
Date of Last Menses (date of last period): MM/DD/YYYY  
Principal Method of Payment: ☐ Medicaid/Oregon Health Plan ☐ Private insurance ☐ Self-pay ☐ Indian Health Services ☐ Champus/Tricare ☐ Other government ☐ Unknown  
Prenatal Care: ☐ Check if none Previous Live Births

☐ Induction of labor ☐ Augmentation of labor ☐ Steroids for fetal lung maturation prior to delivery ☐ Antidotes during labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > = 38C ☐ Epidural or spinal anesthesia during labor ☐ Unknown ☐ None of the above

**DELIVERY**  
Method of Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown  
Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown  
Final Route and Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown  
If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No  
Maternal Morbidity (check all that apply):  
☐ Maternal transfusion ☐ Third or fourth degree perineal laceration ☐ Ruptured uterus ☐ Unplanned hysterectomy ☐ Admission to intensive care unit ☐ None of the above ☐ Unknown at this time  
Mother transferred to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility:  
Infant transferred from this facility after delivery? ☐ Yes ☐ No If yes, name of facility:

Hospital Staff  
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

Last revised: March 2018


## 2) Facility Worksheet: Completed by the facility (BIS, Labor/Delivery Nurse)

# Acknowledgment of Paternity (AOP)

# Did you know there are two Acknowledgement of Paternity (AOP) forms?

- Choose the right form:
  - Hospital **45-31** or
  - notarized affidavit **45-21**?

**AOP's are required to establish paternity if the mom is unmarried at conception, delivery or within 300 days prior to delivery.**

	<h2 style="margin: 0;">Voluntary Acknowledgment of Paternity Affidavit</h2>	<p style="margin: 0; font-size: small;">THIS IS A LEGAL DOCUMENT</p> <p style="margin: 0; font-size: x-small;">Fees: \$35 Filing fee \$25 Birth certificate</p>																																																						
<p style="margin: 0; font-size: x-small;">Order for health benefits</p> <p style="margin: 0;">This document establishes paternity under ORS 43.099. Signatures of the parents below establish paternity and create legally binding duties upon both parents for the child named in this Affidavit, including duty for both parents to financially support the child. Do not sign <u>only</u> you understand your legal rights and responsibilities as stated on the back of this form. Complete in ink and do not alter.</p>																																																								
<p style="margin: 0; font-weight: bold; font-size: small;">SECTION 1 – CHILD (as named on birth certificate)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Child's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: 1px solid black; text-align: center; font-weight: bold; font-size: small;">CSP USE ONLY</td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Child's last new name (as it should appear on both certificates)</p>			Child's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)	CSP USE ONLY																																																
Child's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)	CSP USE ONLY																																																			
<p style="margin: 0; font-weight: bold; font-size: small;">SECTION 2 – NATURAL MOTHER OF CHILD</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Mother's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: none;"></td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Social Security number: _____</p> <p style="margin: 5px 0 0 20px; font-size: x-small;">Date of birth: (mm/dd/yyyy) _____ Birthplace State: (If not United States, name country) _____ Last name before any marriages (Maiden name): _____ Confirmed, Maiden name (last): _____</p>			Mother's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)																																																	
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<p style="margin: 0; font-weight: bold; font-size: small;">SECTION 3 – NATURAL FATHER OF CHILD</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Father's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: none;"></td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Social Security number: _____</p> <p style="margin: 5px 0 0 20px; font-size: x-small;">Date of birth: (mm/dd/yyyy) _____ Birthplace State: (If not United States, name country) _____ Last name before any marriages (Maiden name): _____ Confirmed, Maiden name (last): _____</p>			Father's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)																																																	
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<p style="margin: 0; font-weight: bold; font-size: small;">SECTION 4 – LEGITIMATION</p> <p style="margin: 0; font-size: x-small;">Date of Marriage: _____ County of Marriage: _____</p> <p style="margin: 0; font-size: x-small;">Read and understand birth certificate. The Statement of Rights and Responsibilities, which is on the reverse Voluntary Acknowledgment of Paternity Affidavit.</p> <p style="margin: 0; font-size: x-small;">I acknowledge the following: 1) I am the biological parent of the child; the child's name, birth date, or anyone in between, or 300 days prior to the birth has been determined that I am not the biological parent of the child; 5) I have not and had my parental rights terminated for this child; 6) I am signing this <b>WITNESS NAME AND SIGNATURE – DO NOT SIGN UNTIL NOTARIAL</b></p>																																																								
NOTARIAL	<p style="margin: 0; font-size: x-small;">Mother's printed name: _____ X (M)</p> <p style="margin: 0; font-size: x-small;">Signed in the State of _____ County of _____</p> <p style="margin: 0; font-size: x-small;">This instrument was acknowledged before me on: _____ (Date) _____ Name of me _____ My commission _____</p> <p style="margin: 0; font-size: x-small;">X (Signature of notarial officer)</p> <p style="margin: 0; font-weight: bold; font-size: small;">FATHER'S NAME AND SIGNATURE – DO NOT SIGN UNTIL NOTARIAL</p> <p style="margin: 0; font-size: x-small;">_____ X (F)</p> <p style="margin: 0; font-size: x-small;">Signed in the State of _____ County of _____</p> <p style="margin: 0; font-size: x-small;">This instrument was acknowledged before me on: _____ (Date) _____ Name of me _____ My commission _____</p> <p style="margin: 0; font-size: x-small;">X (Signature of notarial officer)</p>																																																							
	<p style="margin: 0; font-size: x-small;">For Vital Records use only</p> <p style="margin: 0; font-size: x-small;">Date filed: _____</p>																																																							
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<p style="margin: 0; font-weight: bold; font-size: small;">Voluntary Acknowledgment of Paternity</p> <p style="margin: 0; text-align: center; font-weight: bold; font-size: small;">THIS IS A LEGAL DOCUMENT</p> <p style="margin: 0;">This document establishes paternity under ORS 43.099. Do not sign until you understand your legal rights and responsibilities as stated on the back of this form. When both parents complete this document and their signatures are witnessed by hospital staff, this establishes paternity for the child and creates a legal duty for both parents to support their child, which includes financial support. Complete in ink and do not alter.</p> <p style="margin: 0; font-weight: bold; font-size: small;">SECTION 1 – Child (as named on birth certificate)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Child's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: 1px solid black; text-align: center; font-weight: bold; font-size: small;">HOSPITAL USE ONLY CHECK ONE</td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Child's birthplace (hospital or health care facility name): _____</p> <p style="margin: 0; font-weight: bold; font-size: small;">SECTION 2 – Natural mother of child</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Mother's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: none;"></td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Last name before any marriages (Maiden name): _____ Social Security number: _____</p> <p style="margin: 5px 0 0 20px; font-size: x-small;">Date of birth: (mm/dd/yyyy) _____ Birthplace State: (If not United States, name country) _____ Daytime telephone number: _____</p> <p style="margin: 0; font-weight: bold; font-size: small;">SECTION 3 – Natural father of child</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20%;">Father's name:</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Middle</td> <td style="width: 10%;">Last</td> <td style="width: 10%;">Suffix (Example: Jr. or Sr.)</td> <td style="width: 40%; border: none;"></td> </tr> </table> <p style="margin: 5px 0 0 20px; font-size: x-small;">Present address: No. and Street _____ City _____ State _____ ZIP _____ Social Security number: _____</p> <p style="margin: 5px 0 0 20px; font-size: x-small;">Date of birth: (mm/dd/yyyy) _____ Birthplace State: (If not United States, name country) _____ Daytime telephone number: _____</p> <p style="margin: 0; font-weight: bold; font-size: small;">SECTION 4 – Witnessed signatures</p> <p style="margin: 0;">Read and understand before you sign this document. Do not sign until hospital witness is present.</p> <p style="margin: 0; font-size: x-small;">It is a Class C felony for any person to make any false statement or supply false information intending that the information be used in the preparation of any certificate. The Statement of Rights and Responsibilities, which is on the reverse side of this Acknowledgment, must have been read to you prior to the signing of this Voluntary Acknowledgment of Paternity.</p> <p style="margin: 0; font-size: x-small;">I acknowledge the following: 1) I am the biological parent of the child; the above information is true; 2) the mother was not married to anyone at the time of the child's conception, birth, or anytime in between, or 300 days prior to the birth of the child; 3) I have not consented to the adoption of the child; 4) I have not been determined that I am not the biological parent of the child; 5) I have not surrendered my parental rights to a public or private child-care agency, and have not had my parental rights terminated; 6) I am signing this Acknowledgment for the purpose of establishing paternity of the child.</p> <p style="margin: 0; font-weight: bold; font-size: small;">Do not sign until hospital witness is present.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 40%; border: none;"></td> <td style="width: 10%; text-align: center; font-weight: bold; font-size: small;">X</td> <td style="width: 40%; border: none;"></td> </tr> <tr> <td style="border: none;">Mother's printed name</td> <td style="border: none;"></td> <td style="border: none;">Mother's signature</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Date signed</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center; font-weight: bold; font-size: small;">X</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Hospital witness' printed name</td> <td style="border: none;"></td> <td style="border: none;">Hospital witness' signature</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Date witnessed</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center; font-weight: bold; font-size: small;">X</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Father's printed name</td> <td style="border: none;"></td> <td style="border: none;">Father's signature</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Date signed</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center; font-weight: bold; font-size: small;">X</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Hospital witness' printed name</td> <td style="border: none;"></td> <td style="border: none;">Hospital witness' signature</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Date witnessed</td> </tr> </table> <p style="margin: 0; font-size: x-small;">Name of hospital facility: _____ City _____ State _____</p> <p style="margin: 0; font-size: x-small;">Per ORS 160.076(6), Paternity is established upon filing of this form by the State Registrar of the Center for Health Statistics.</p>			Child's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)	HOSPITAL USE ONLY CHECK ONE	Mother's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)		Father's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)			X		Mother's printed name		Mother's signature			Date signed		X		Hospital witness' printed name		Hospital witness' signature			Date witnessed		X		Father's printed name		Father's signature			Date signed		X		Hospital witness' printed name		Hospital witness' signature			Date witnessed
Child's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)	HOSPITAL USE ONLY CHECK ONE																																																			
Mother's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)																																																				
Father's name:	First	Middle	Last	Suffix (Example: Jr. or Sr.)																																																				
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Mother's printed name		Mother's signature																																																						
		Date signed																																																						
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Hospital witness' printed name		Hospital witness' signature																																																						
		Date witnessed																																																						
	X																																																							
Father's printed name		Father's signature																																																						
		Date signed																																																						
	X																																																							
Hospital witness' printed name		Hospital witness' signature																																																						
		Date witnessed																																																						

# Use AOP 45-31: Hospital or Birthing Center



## Use AOP 45-31

- While the mother is **still a patient at the facility**
- It must be signed and dated WITHIN 5 days after the date of birth
- Must be signed and dated IN FRONT of birth facility witness

# Responsibilities of the Birth Information Specialist or Midwives within a Facility:

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- ✓ Provide the Voluntary Acknowledgment of Paternity (45-31) form to unmarried moms. If moms don't complete, then provide notarized form.
- ✓ Ensure parents have heard the Rights and Responsibilities before completing form. They are found on the back of the form.
- ✓ Check the form for accuracy and completeness before submitting to the state.
- ✓ Make sure parents have signed and dated the form.
- ✓ Make sure the form is witnessed and dated by hospital staff.

# Responsibilities of the Birth Information Specialist or Midwives within a Facility:

---

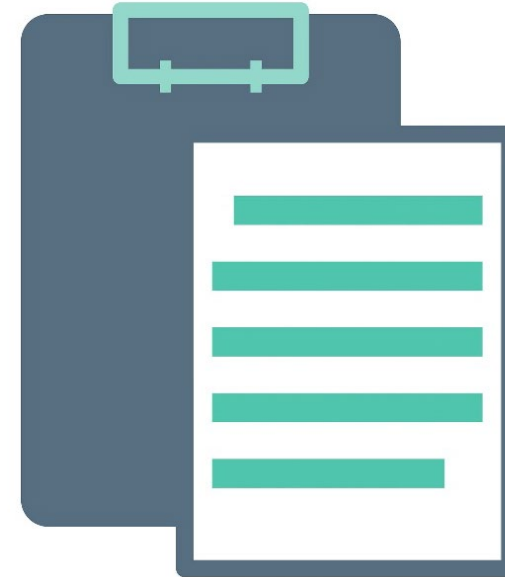
- ✓ Make sure the dates the parents sign match the witness dates.
- ✓ The child's name on the AOP matches what is on the birth record
- ✓ The parents' names match the names on the birth record
- ✓ Names and dates associated with signatures must be handwritten ONLY
- ✓ Minor alterations only, and must be initialed by the person making the change
- ✓ All fields on the form must be completed
- ✓ Ensure that the father info entered in OVERS matches the AOP exactly.
- ✓ Include OVERS Case ID

# Affidavit 45-21

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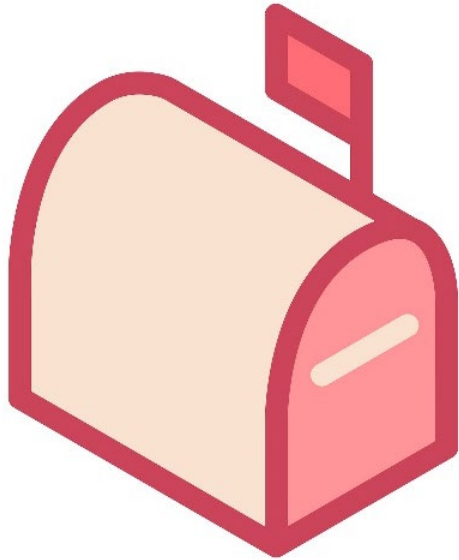
## ...OR if parents don't complete the AOP at the facility

- Send parents home with the Affidavit 45-21 if the parents leave without signing the hospital form. This will allow them to add paternity later.
- It must be signed before a notary



# Submitting the AOP to the State

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- The form should be submitted as soon as possible – do not hold to mail in batches.
- Order and use white prepaid envelopes.
- The form ***must*** be mailed by the facility and **postmarked** within **14 days** of the child's date of birth.

# **More information on paternity establishment**

[FAQ: Establishing Paternity](#)

[Paternity Forms and Instructions](#)



# Responsibilities of Birth Information Specialists: Reporting Fetal Deaths

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## What is a fetal death?

ORS 432.005 (14) "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of the voluntary muscles.

# Highlights of the laws and policies related to fetal deaths

---

- ❑ All fetal deaths that occur in Oregon must be filed with the state.
- ❑ Each fetal death of 350 grams or more or if the weight is unknown, of 20 completed weeks gestation or more, must be submitted to the state within 5 calendar days after delivery.
- ❑ The hospital or licensed birthing facility where the fetal death occurred is responsible for filing the record with the state.
- ❑ Fetal deaths that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.
- ❑ Information is gathered using the fetal death report worksheets.

# Responsibilities of Birth Information Specialist: Fetal Deaths

---


- **432.143 Mandatory submission and registration of reports of fetal death; persons required to report; rules.** (1)(a) A report of each fetal death of 350 grams or more or, if the weight is unknown, of 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of the delivery, that occurs in this state shall be submitted within five calendar days after the delivery to the Center for Health Statistics ...
- (2) When fetal death occurs in an institution or on route to an institution, the person in charge of the institution or an authorized designee shall obtain all data required by the state registrar, prepare the report of fetal death, certify by electronic signature that the information reported is accurate and complete and submit the report as described in subsection (1) of this section.

For more information specific to Fetal Death visit the CHS website [BIS page](#). Scroll down to the Fetal Death section.



How to Register Fetal Death Reports

Please print neatly



**Oregon Health Authority**  
Center for Health Statistics

**FETAL DEATH REPORT**  
FACILITY WORKSHEET

*Only use this form to report a Fetal Death*

*Do NOT file a fetal death report if the delivery resulted in a live birth, regardless of duration. A fetal death is indicated by the fact that after delivery, the fetus does not breathe or show any other evidence of life. If after delivery the fetus showed any evidence of life, you are required to complete BOTH a certificate of live birth and death. A fetal disposition permit can only be used for a fetal death. A planned induced termination of pregnancy is NOT a fetal death.*

<b>FETUS</b>				<b>Date of Delivery</b>		<b>Time of Delivery</b>		<b>Sex</b>	
Fetus Name First Middle Last Suffix				MM / DD / YYYY		AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/>		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	
<b>METHOD OF DISPOSITION (Select one)</b>									
Facility releasing fetus for Final Disposition; hospital must provide a disposition permit to any party transporting remains: <input type="checkbox"/> Hospital released fetus to parents <input type="checkbox"/> Hospital released fetus to funeral home (name) _____									
<b>MOTHER'S HEALTH</b>					<b>PRENATAL</b>				
Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No					Date of Last Menses MM / DD / YYYY				
Height _____ Cigarettes Smoked Per Day _____					Previous Live Births Date of last live birth MM / YYYY (Does not include this fetus)				
3 months before pregnancy # _____ Cigarettes 1 <sup>st</sup> 3 months of pregnancy # _____ Cigarettes 2 <sup>nd</sup> 3 months of pregnancy # _____ Cigarettes 3 <sup>rd</sup> 3 months of pregnancy # _____ Cigarettes					# now living _____ # now deceased _____				
					No Prenatal Care <input type="checkbox"/> OR Date of 1 <sup>st</sup> visit MM / DD / YYYY				
<b>PREGNANCY FACTORS</b>									
Risk Factors <input type="checkbox"/> Diabetes-Pre-pregnancy <input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation) <input type="checkbox"/> Diabetes-Gestational (Diagnosis In This Pregnancy) <input type="checkbox"/> Infertility Treatment-Fertility-enhancing drugs <input type="checkbox"/> Hypertension-Pre-pregnancy (Chronic) <input type="checkbox"/> Infertility Treatment-Assisted Reproductive Technology <input type="checkbox"/> Hypertension-Gestational (PIH, Pre-eclampsia) <input type="checkbox"/> Mother Had A Previous Cesarean Delivery: How Many? _____ <input type="checkbox"/> Hypertension-Eclampsia <input type="checkbox"/> None Of The Above									
<b>DELIVERY</b>									
Method of Delivery				If Cesarean, was a Trial of Labor Attempted?			Maternal Morbidity (check all that apply)		
Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> None of the above		
Final Route and Method of Delivery <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Cesarean				Mother Transferred for maternal or fetal indication prior to delivery <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____					
<b>FETAL ATTRIBUTES</b>									
Weight of Fetus <input type="checkbox"/> lb/oz <input type="checkbox"/> grams			Obstetric Estimate of Gestation (weeks) _____		Plurality (Single, Twin, Triplet, etc.) _____		Delivery Order (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , 4 <sup>th</sup> , etc.) _____		
<b>CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH</b>									
Initiating Cause/Conditioning (enter one condition or cause only)					Other Significant Cause/Condition (enter other conditions or causes)				
Maternal Conditions/Disease (specify) _____					Maternal Conditions/Disease (specify) _____				
Complications of placenta, cord or membranes:					Complications of placenta, cord or membranes:				
<input type="checkbox"/> Rupture of membranes <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Other					<input type="checkbox"/> Rupture of membranes <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Other				
Other obstetrical or pregnancy complications(specify) _____					Other obstetrical or pregnancy complications(specify) _____				
Fetal Anomaly (specify) _____					Fetal Anomaly(specify) _____				
Fetal Injury(specify) _____					Fetal Injury(specify) _____				
Fetal Infection (specify) _____					Fetal Infection (specify) _____				
Other fetal conditions/disorders (specify) _____					Other fetal conditions/disorders (specify) _____				
<input type="checkbox"/> Unknown					<input type="checkbox"/> Unknown				
Estimated time of fetal death <input type="checkbox"/> Dead at first assessment, no labor ongoing					<input type="checkbox"/> Dead at first assessment, labor ongoing				
<input type="checkbox"/> Died during labor, after first assessment					<input type="checkbox"/> Unknown time of fetal death				
Autopsy performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned					Histological Placental Examination Performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned				
Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable									
Attendant at delivery First Middle Last Title									
Facility to obtain ID tag number from funeral home where remains released to: ID TAG NUMBER _____									

---

# **The Oregon Vital Events Registration System (OVERS)**

**A brief introduction and live demonstration**

[illegible]



# ***Birth Record Facility Worksheet and OVERS***

## Oregon Health Center for Health Statistics

# Birth Record FACILITY WORKSHEET

(Page 1 of 2)

Please print neatly

**CHILD**  
Name \_\_\_\_\_ Sex \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Time of Birth \_\_\_\_\_  
Male ☐ Female ☐ Unknown ☐

**MOTHER HEALTH**  
Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown ☐

Height \_\_\_\_\_ Weight \_\_\_\_\_  
(Pre-pregnancy) (At delivery)

Alcohol use during this pregnancy? ☐ Yes ☐ No ☐ If yes, average number of drinks per week? \_\_\_\_\_

**PLACE OF BIRTH**  
☐ At this facility ☐ Home delivery ☐ Other location (specify) \_\_\_\_\_  
Specify address if not this facility: \_\_\_\_\_

**PRENATAL**  
Mother's Medical Record # (optional): \_\_\_\_\_  
Mother's Medicaid #: \_\_\_\_\_  
Date of Last Menses (date of last period): \_\_\_\_\_  
Prenatal Care ☐ Check if none \_\_\_\_\_  
Date of 1st visit \_\_\_\_\_ Total # of visits \_\_\_\_\_  
Other Pregnancy Outcomes (Spontaneous, induced, terminations or ectopic pregnancy) \_\_\_\_\_  
Combined # of other outcomes \_\_\_\_\_ Date of last other outcome: \_\_\_\_\_

**PREGNANCY FACTORS**  
Risk Factors:  
☐ Diabetes - Gestational  
☐ Diabetes - Pre-pregnancy  
☐ Hypertension - Pre-pregnancy (Chronic)  
☐ Hypertension - Gestational  
Mother tested for:  
☐ Syphilis  
☐ Group B Strep  
Infections Present and/or Treated:  
☐ Gonorrhea  
☐ Syphilis  
Hepatitis B ☐ Hepatitis C ☐ None of the above  
Obstetric Procedures:  
☐ External cephalic version  
☐ Successful ☐ Failed  
Pregnancy Resulted from Infertility Treatment -  
☐ Assisted Reproductive Technology  
☐ Mother Had A Previous Cesarean Delivery  
☐ None of the Above

**LABOR**  
Characteristics of Labor and Delivery:  
☐ Induction of labor  
☐ Augmentation of labor  
☐ Prolonged labor (more than 12 hours prior to delivery)  
Antibiotics during labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > 38.0  
None of the above

**DELIVERY**  
Method of Delivery:  
Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown  
Final Route and Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown  
If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No  
Maternal Mortality (check all that apply):  
☐ Maternal transfusion  
☐ Third or fourth degree perineal laceration  
☐ Unplanned hysterectomy  
☐ Admission to intensive care unit  
Mother transferred to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility \_\_\_\_\_  
Infant transferred from this facility after delivery? ☐ Yes ☐ No If yes, name of facility \_\_\_\_\_

Hospital Staff

## NEWBORN

Medical Rec. # (optional): \_\_\_\_\_  
Number born alive this Gestation: \_\_\_\_\_ Birth Weight: \_\_\_\_\_  
Parity: (Single Twin Triplet etc.) \_\_\_\_\_  
Infant alive at time of report ☐ Yes ☐ No Infant transferred at discharge ☐ Yes ☐ No

**NEWBORN FACTORS**  
☐ Abnormal Conditions of the Newborn  
☐ Assisted ventilation or blood transfusion  
☐ Not a resident of Oregon  
☐ Congenital Anomalies  
☐ Congenital Heart Disease  
☐ Congenital Lung Disease  
☐ Congenital Kidney Disease  
☐ Congenital Endocrine Disease  
☐ Congenital Hematologic Disease  
☐ Congenital Infectious Disease  
☐ Congenital Musculoskeletal Disease  
☐ Congenital Neurological Disease  
☐ Congenital Skin Disease  
☐ Congenital Vision/Hearing Impairment  
☐ Congenital Immune Deficiency  
☐ Congenital Metabolic Disease  
☐ Congenital Hematologic Disease  
☐ Congenital Endocrine Disease  
☐ Congenital Kidney Disease  
☐ Congenital Lung Disease  
☐ Congenital Heart Disease  
☐ Congenital Anomalies  
☐ Abnormal Conditions of the Newborn  
☐ Assisted ventilation or blood transfusion  
☐ Not a resident of Oregon

**ATTENDANT**  
Attendant at delivery \_\_\_\_\_  
Type of delivery: \_\_\_\_\_  
Type of anesthesia: \_\_\_\_\_  
Type of analgesia: \_\_\_\_\_  
Type of sedation: \_\_\_\_\_  
Type of anesthesia: \_\_\_\_\_  
Type of analgesia: \_\_\_\_\_  
Type of sedation: \_\_\_\_\_

**HEARING SCREENING**  
These items are not required to certify the birth and can be added after the birth report is certified.  
Infant screened for hearing? ☐ Yes ☐ No  
Screening method: \_\_\_\_\_  
Screening result: \_\_\_\_\_  
Screening date: \_\_\_\_\_  
Screening location: \_\_\_\_\_  
Screening provider: \_\_\_\_\_  
Screening equipment: \_\_\_\_\_  
Screening results: \_\_\_\_\_  
Screening date: \_\_\_\_\_  
Screening location: \_\_\_\_\_  
Screening provider: \_\_\_\_\_  
Screening equipment: \_\_\_\_\_  
Screening results: \_\_\_\_\_

**TESTING**  
These items are not required to certify the birth and can be added after the birth report is certified.  
Infant tested for: \_\_\_\_\_  
Test date: \_\_\_\_\_  
Test location: \_\_\_\_\_  
Test provider: \_\_\_\_\_  
Test equipment: \_\_\_\_\_  
Test results: \_\_\_\_\_  
Test date: \_\_\_\_\_  
Test location: \_\_\_\_\_  
Test provider: \_\_\_\_\_  
Test equipment: \_\_\_\_\_  
Test results: \_\_\_\_\_

**TESTING**  
These items are not required to certify the birth and can be added after the birth report is certified.  
Infant tested for: \_\_\_\_\_  
Test date: \_\_\_\_\_  
Test location: \_\_\_\_\_  
Test provider: \_\_\_\_\_  
Test equipment: \_\_\_\_\_  
Test results: \_\_\_\_\_  
Test date: \_\_\_\_\_  
Test location: \_\_\_\_\_  
Test provider: \_\_\_\_\_  
Test equipment: \_\_\_\_\_  
Test results: \_\_\_\_\_

Last revised: March 2018

No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

Facility staff might not be able to access the original record when entering the birth record for any reason. Please call 1-800-452-6666 for assistance.

Last revised: March 2018

Facility staff might not be able to access the original record when entering the birth record for any reason. Please call 1-800-452-6666 for assistance.

- Consult with your facility about correct ways to gather information for the worksheet.
- Use the Guidebook to locate detailed definitions

# Use the Guides for help with definitions

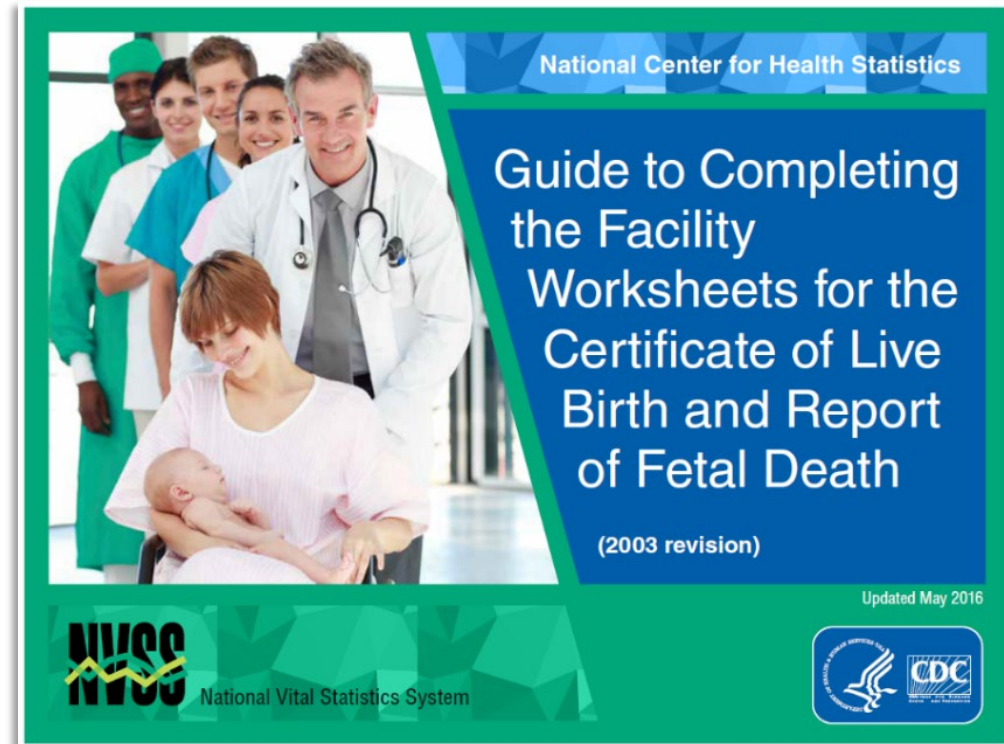
Click the image to view the guides.

## OREGON BIRTH REPORT INSTRUCTIONS

### Oregon Vital Events Registration System (OVERS) *Oregon Birth Report Instructions*

**Birth Information Specialist User Guide**  
Revised September 2023

**Oregon Health**  
Authority  
Public Health Division  
Center for Public Health Practice  
Center for Health Statistics





# Watch the OVERS Demonstration Tutorial

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[Click here for the OVERS Demonstration tutorial](#)



Learn how to:

- Become familiar with OVERS
- Enter a birth record
- What to do in case of errors
- Certify a record

# Things to remember

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- ❑ Entries in OVERS create an official birth record.
- ❑ Review your entries for errors.
- ❑ Amendments are listed permanently as footnote on the certificate.
- ❑ Worksheets should inform OVERS entry.

# Print your Certificate of Completion

- After completing this training and watching the OVERS Demonstration Tutorial, print your Certificate of Completion by clicking [here](#).
- Enter your name on the certificate before printing it.



---

# **Birth Information Specialist training from CDC Train**

# CDC Required Training Course

---

Take the required eLearning training and print the certificate found at the link below:

**Applying Best Practices for Reporting Medical and Health Information on Birth Certificates\***

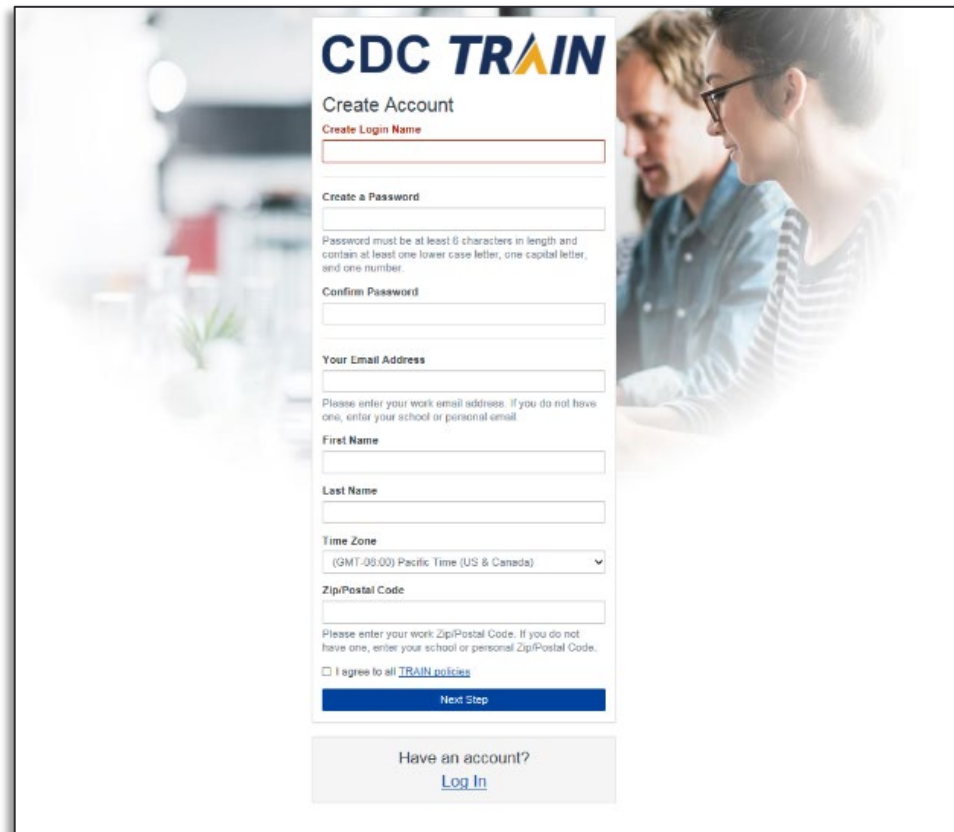
*(Created by CDC Train).*



**\*You must create a CDC Train account to receive a certificate at the end of the training.**

# Login to CDC Train and complete your profile

You can find step-by-step instructions by clicking [here](#).

A screenshot of the CDC TRAIN 'Create Account' form. The form is overlaid on a background image of two people working. The form fields include: 'Create Login Name' (text input), 'Create a Password' (text input with a note: 'Password must be at least 6 characters in length and contain at least one lower case letter, one capital letter, and one number.'), 'Confirm Password' (text input), 'Your Email Address' (text input with a note: 'Please enter your work email address. If you do not have one, enter your school or personal email.'), 'First Name' (text input), 'Last Name' (text input), 'Time Zone' (dropdown menu showing '(GMT-08:00) Pacific Time (US & Canada)'), 'Zip/Postal Code' (text input with a note: 'Please enter your work Zip/Postal Code. If you do not have one, enter your school or personal Zip/Postal Code.'), and a checkbox for 'I agree to all TRAIN policies'. At the bottom of the form is a blue 'Next Step' button. Below the form is a link for 'Have an account? Log In'.

# Print the certificate for the CDC Applying Best Practices Course

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- Click on the Certificate button which will appear when the course is complete.
- Click the download link.
- Print the certificate.

 **Applying Best Practices for Reporting Medical and Health Information on Birth Certificates (Web-based) - WB4312R**

[< Back](#) [History](#) [+ Register](#) [Certificate](#)

 Completed ✓ Verified Web-based Training - Self-study ID 1111551 Skill level: Introductory 1h Course Number WB4312R

📅 Publish date Jun 25, 2023 9:00 PM PDT 📅 Expiration Date Jun 25, 2025 8:59 PM PDT

★★★★☆ (101)

Continuing Education Start Date  
Jun 24, 2023 9:00 PM PDT

Continuing Education End Date  
Jun 25, 2025 8:59 PM PDT

This course offers continuing education (CE). When registering for the course, please select each type of CE you would like to apply for. To earn CE, you must pass the post-assessment and complete the evaluation by June 25, 2025.

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**What is needed for an OVERS account**



# To complete your enrollment in OVERS

Email or fax the following completed documentation to:

- Email: [CHS.OVERSAccess@oha.oregon.gov](mailto:CHS.OVERSAccess@oha.oregon.gov)
- Fax: 971-673-1201

1. [OVERS Enrollment Form](#)
2. [OVERS Training Certificate of Completion](#)
3. Applying Best Practices Certificate from CDC Train.
4. Letter on letterhead from your supervisor granting you permission to access the records at your facility.
5. Two pieces of ID

Once we receive the documentation, you will receive your OVERS log in and password information.



The image displays two documents from the Oregon Health Authority. The top document is the 'OVERS Registration Application' form, which includes fields for personal and professional information, a signature line, and checkboxes for various roles like Medical Director, Medical Certifier, and Medical Examiner. The bottom document is a 'CERTIFICATE of COMPLETION' for the 'Oregon Birth Information Specialist Training 2025'. It features a gold seal with the year '2025', a signature line with the name 'Kathy Ellis' and title 'Vital Records Trainer', and the Oregon Health Authority logo.

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## **Resources and Contacts**

# CHS Resources

- [Quick Start Guide](#)
- [Birth Facility User Guide](#)
- [Instructions and Worksheets](#)
- [Birth Page](#)

OVERS Quick Start Guide for Birth Information Specialists (revised 6/2022)

## 1. Getting Started

- Login at: <https://or-vitalevents.hr.state.or.us/overs>
- To start a new record or locate a record that needs to be completed go to Life Events > Birth > Start/Edit New Case

## 2. Entering Birth Certificate Data

Complete each page under the Parent Information and Facility Information subheading in the Birth Registration Menu.

Birth Registration Menu	
Parent Information	
Child	
Mother	
Mother Address	
Mother Demographics	
Mother Disability	
Mother Health	
Marital Status	
Father	
Father/2nd Parent Demographics	
Father/2nd Parent Disability	
Informant	
Facility Information	
Place of Birth	
Prenatal	
Pregnancy Factors	
Labor	
Delivery	
Newborn	
Newborn Factors	
Attendant/Certifier	

- ✓ [Green check mark] There are no errors on the page. You may certify the report. (See step 4 below.)
- ⚠ [Yellow circle] Click on the page with the yellow circle next to it. *Carefully read the error message.* You may: 1) edit and save the information, then click Validate Page again, or 2) confirm your entry is accurate by clicking the **Override** box, then click **Save Overrides**. *It will remain a yellow circle even after you override the message. This is acceptable.*
- ✗ [Red X] Go to the page with the red x symbol. You must edit the item highlighted in red to complete the report.

## 4. Certify the Birth Record

- After all corrections and overrides are complete, the **Certify** link will appear below the **Attendant/Certifier** link. Click on **Certify**.
- Read the affirmation statements. Click the check boxes to affirm the statements.
- Click **Affirm**. The page will refresh then show **Authentication Successful**.
- The report is complete.

Facility Information	
Place of Birth	
Prenatal	
Pregnancy Factors	
Labor	
Delivery	
Newborn	
Newborn Factors	
Attendant/Certifier	
<b>Certify</b>	

Birth Information Specialists

Vital Records and Certificates

Frequently Asked Questions

Contact Us

Key Resources

[Matters of Record Newsletter](#)

A monthly newsletter with up-to-date informative articles for our partners.

[CHS Partner FAQ](#)

This page contains a comprehensive list of all the Center for Health Statistics Frequently Asked Questions for our Partners. Type in keywords in the "Search" box to narrow your results. If you do not find the question or answer you are looking for, please email [Partner Services](#).

**Required Training**

All birth information specialists and midwives are required to complete both the Center for Health Statistics Training and the National Training. Certificates verifying completion of these training will be required before a new OVERS account can be created. To complete the required training, complete the steps listed [below](#).

**OVERS Help Desk - Technical Support: 971-673-0279**

The OVERS Help Desk is available to answer questions Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time. If you reach the voicemail, leave a detailed and clear message including your name, phone number, case ID, and issue that you are experiencing with OVERS, and we will return your call as soon as we can.

**Forgot your password?**

Click the "Forgot your password?" link at the bottom of the [OVERS login screen](#).

- Username is case sensitive and must be correct.
- See the [Quick Reference Guide](#) for step-by-step instructions to reset your OVERS password.

[Partner Contact Us](#)

Site Navigation

# Contacts

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**971-673-0279**

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Vital Records Trainer

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