The Oregon Birth Certificate
Birth Information Specialist Training
2018

Public Health Division
Center for Public Health Practice
Center for Health Statistics
July 10 & 12, 2018

Oregon Health Authority

Presenters

Lindsey Zapata, OVERS Training Coordinator
Judy Shioshi, Vital Records Field Liaison

Today's Agenda

Policies & procedures for Birth Information Specialists

- Birth
- Paternity
- Fetal Death

An introduction to the worksheets

A live demonstration of OVERS entry

Next Steps

The work you do is of VITAL importance

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

For the family:
Cannot establish an identity for this child. No benefits, tax credits, health care… no identity.

National health:
The information from the records you enter is critical to identifying and quantifying health related issues and measuring indicators of the nation's health. Policy development, funding and research depend on this important information – that you are entering!

Policies and Procedures for Birth Records

Oregon Revised Statutes

Chapter 432 (2017 Edition)

The Law

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.

Who

In 2017 44,159 births occurred in Oregon

99%

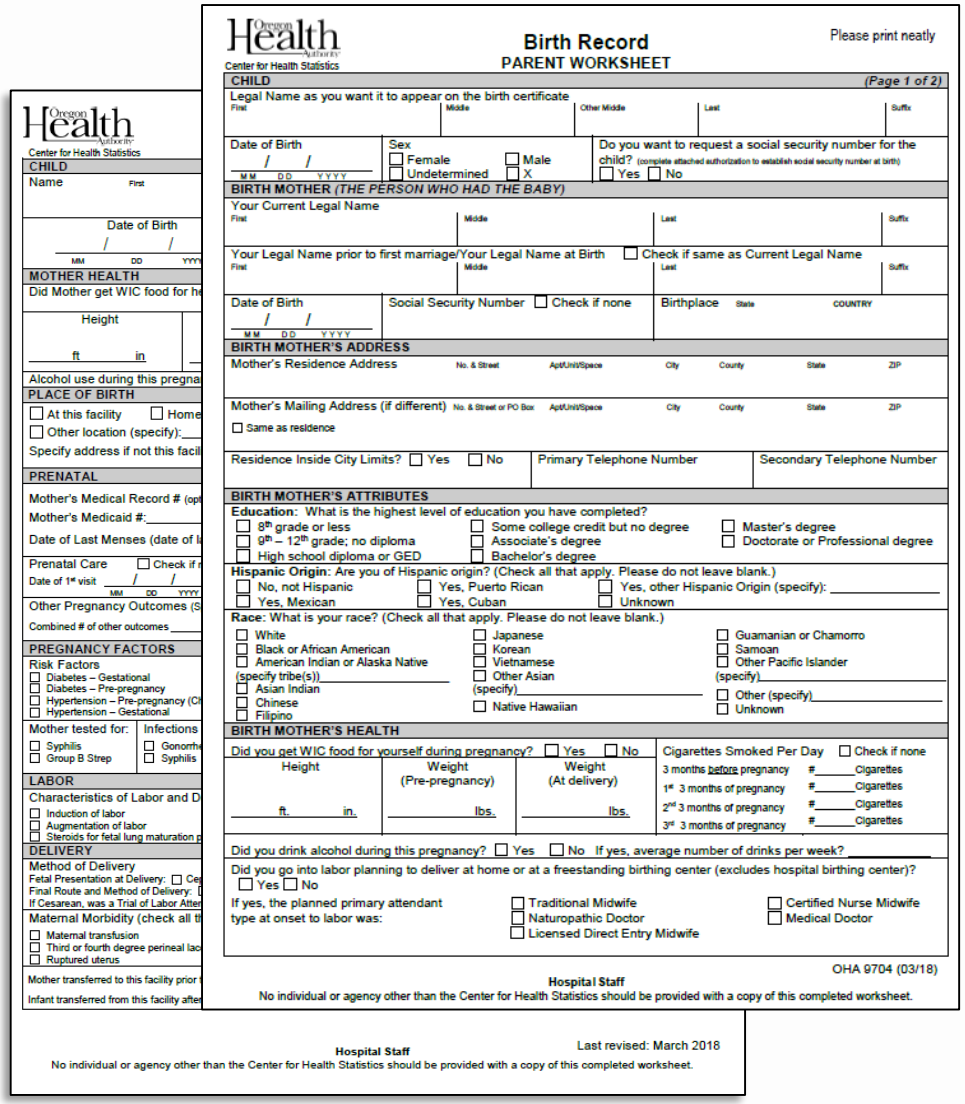
Birth Records

- **When Birth Information Specialists (BIS) or midwives certify birth records in OVERS, birth records will automatically register - if there is no override or error on the record.**

Worksheets

Parent and Facility Worksheets

- **Parent Worksheet: Completed by the parent**
- **Facility Worksheet: Completed by the facility staff (BIS, Labor/Delivery Nurse)**
- **Consult with your manager about your facility's procedure for completing the worksheets.**



Oregon Health Authority
Center for Health Statistics

Birth Record
PARENT WORKSHEET

Please print neatly

CHILD *(Page 1 of 2)*

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

BIRTH MOTHER'S ATTRIBUTES

Education: What is the highest level of education you have completed?
- 8th grade or less
- 9th – 12th grade; no diploma
- High school diploma or GED
- Some college credit but no degree
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctorate or Professional degree

Hispanic Origin: Are you of Hispanic origin? (Check all that apply. Please do not leave blank.)
- No, not Hispanic
- Yes, Mexican
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Hispanic Origin (specify):
- Unknown

Race: What is your race? (Check all that apply. Please do not leave blank.)
- White
- Black or African American
- American Indian or Alaska Native (specify tribe(s))
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (specify)
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (specify)
- Other (specify)
- Unknown

BIRTH MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy? Yes No

Height	Weight (Pre-pregnancy)	Weight (At delivery)
ft. in.	lbs.	lbs.

Cigarettes Smoked Per Day — Check if none
- 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
- Naturopathic Doctor
- Licensed Direct Entry Midwife
- Certified Nurse Midwife
- Medical Doctor

OHA 9704 (03/18)

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

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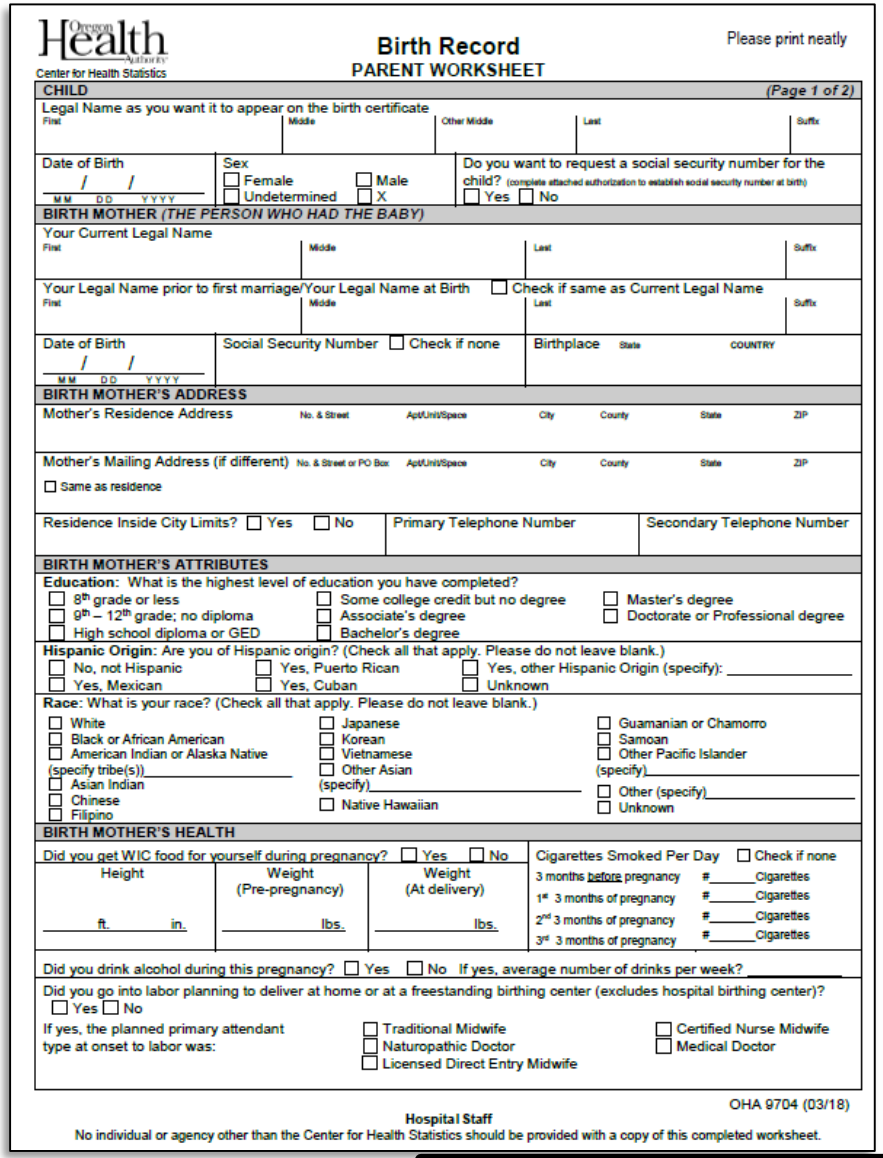
PUBLIC HEALTH DIVISION
Center for Health Statistics

IMPORTANT:
This is a legal document, once filed it is part of the permanent birth record

Oregon Health Authority



Oregon Health Authority
Center for Health Statistics

Birth Record
PARENT WORKSHEET

Please print neatly

CHILD *(Page 1 of 2)*

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

BIRTH MOTHER'S ATTRIBUTES

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☐ 8th grade or less
☐ 9th – 12th grade; no diploma
☐ High school diploma or GED
☐ Some college credit but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate or Professional degree

Hispanic Origin: Are you of Hispanic origin? (Check all that apply. Please do not leave blank.)
☐ No, not Hispanic
☐ Yes, Mexican
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Hispanic Origin (specify): _____
☐ Unknown

Race: What is your race? (Check all that apply. Please do not leave blank.)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify tribe(s)) _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (specify) _____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (specify) _____
☐ Other (specify) _____
☐ Unknown

BIRTH MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy? ☐ Yes ☐ No

Height	Weight (Pre-pregnancy)	Weight (At delivery)
ft. in.	lbs.	lbs.

Cigarettes Smoked Per Day ☐ Check if none
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
☐ Naturopathic Doctor
☐ Licensed Direct Entry Midwife
☐ Certified Nurse Midwife
☐ Medical Doctor

OHA 9704 (03/18)

Hospital Staff
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Parent Worksheet

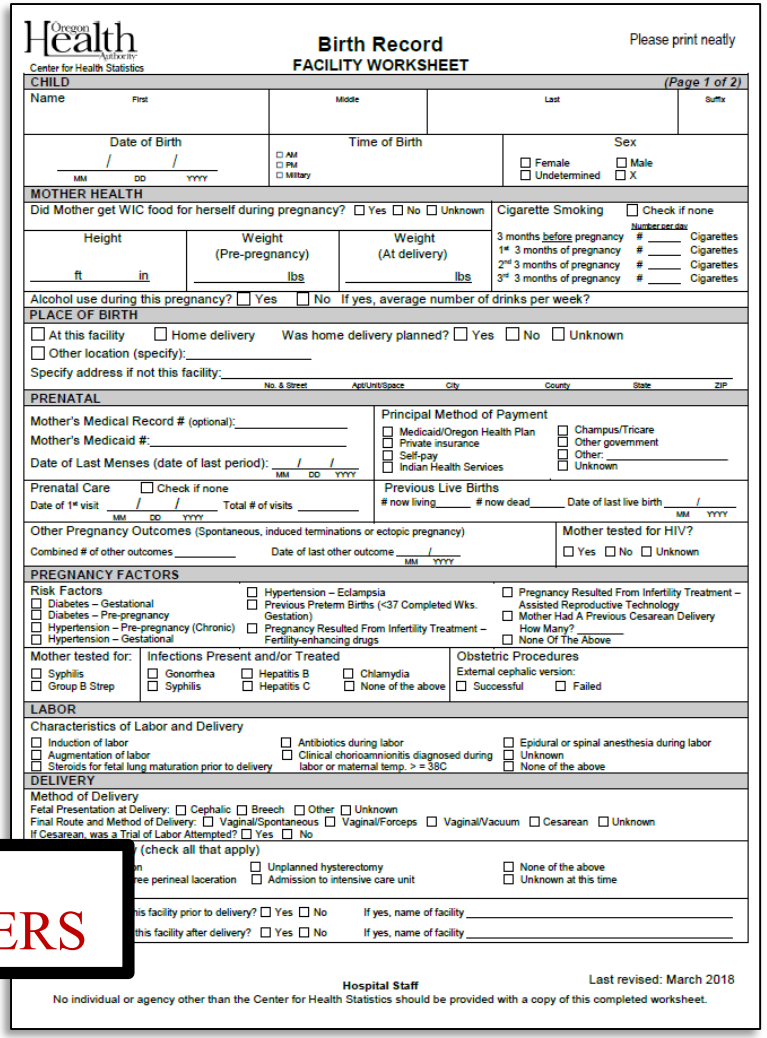
- Baby's information
- Parents' address and demographics
- Legal relationship of parents
- Mother's health
- Prenatal
- Social Security Number authorization

IMPORTANT:
The parent must read the cover sheet

Facility Worksheets

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

IMPORTANT:
The worksheet correlates with OVERS



Oregon Health Authority
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)

Height: ft in

Weight (Pre-pregnancy): lbs

Weight (At delivery): lbs

3 months before pregnancy # ____ Cigarettes
1st 3 months of pregnancy # ____ Cigarettes
2nd 3 months of pregnancy # ____ Cigarettes
3rd 3 months of pregnancy # ____ Cigarettes

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)

Principal Method of Payment
☐ Medicaid/Oregon Health Plan ☐ Champus/Tricare
☐ Private insurance ☐ Other government
☐ Self-pay ☐ Other:_____
☐ Indian Health Services ☐ Unknown

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

Infections Present and/or Treated
☐ Gonorrhea ☐ Hepatitis B ☐ Chlamydia
☐ Syphilis ☐ Hepatitis C ☐ 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
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

(check all that apply)
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ None of the above
☐ Unknown at this time

...his facility prior to delivery? ☐ Yes ☐ No If yes, name of facility _____
...this facility after delivery? ☐ Yes ☐ No If yes, name of facility _____

Hospital Staff
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Last revised: March 2018

Paternity

Responsibilities according to Oregon Law

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]

Paternity Acknowledgment

Responsibilities of the Birth Information Specialist:

- Provide the correct and most recent form -- use the 2016 form only
- Ensure parents have heard the Rights and Responsibilities before completing form
- Check the form for accuracy and completeness before submitting to the state
- Submitting the form to the state use prepaid envelopes
- The form should be submitted as soon as possible – do not hold to mail in batches
- To avoid amendment fees, the form must be mailed by the facility and postmarked within 14 days of the child's date of birth

IMPORTANT:
This is a legal document, once filed it is part of the permanent birth record

Paternity Acknowledgment

Mother is unwed

(and has not been married for 300 days prior to birth) --

Complete the

AOP 45-31: Hospital or Birthing Center form

Use AOP 45-31

- Completed by parents while mother is still a patient at the facility
- Must be signed and dated by parents WITHIN 5 days after the date of birth
- Must be signed and dated IN FRONT of birth facility staff witness

…OR provide parents with the AOP 45-21:

Use AOP Affidavit 45-21

- Provide this form if AOP is not completed within 5 days of date of birth or after mother leaves the facility
- Must be signed before a notary

Fetal Death

For more information specific to Fetal Death

Visit our [our web page.]

Oregon Health Authority
Center for Health Statistics

FETAL DEATH REPORT
PARENT WORKSHEET

Please print neatly

FETUS *(Page 1 of 2)*

Fetus Name
First | Middle | Other Middle | Last | Suffix

METHOD OF DISPOSITION – Parents' selection

Disposition method: ☐ Burial ☐ Cremation ☐ Hospital disposition ☐ Donation ☐ Removal from state
☐ Other_____

Facility Coordinating Final Disposition

☐ Hospital to release fetus to funeral home Name of Funeral facility: _____
☐ Hospital to release fetus to parents (must provide parents with a disposition permit for transporting remains)

MOTHER

Mother's Current Legal Name
First | Middle | Last | Suffix

Mother's Legal Name prior to first marriage/as it appears on your birth certificate ☐ Check if same as current Legal Name
First | Middle | Last | Suffix

Mother's Date of Birth ___/___/___ (MM DD YYYY) | Birthplace State or Canadian Province COUNTRY

MOTHER'S ADDRESS

Mother's Resident Address No. & Street City County State ZIP | Inside City Limits? ☐ Yes ☐ No

MOTHER'S ATTRIBUTES

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

Hispanic Origin (Check all that apply. Do not leave blank.)
☐ No, not Spanish/Hispanic/Latina ☐ Yes, Puerto Rican ☐ Yes, other Hispanic Origin (specify):_____
☐ Yes, Mexican, Mexican-American, Chicana ☐ Yes, Cuban ☐ Unknown

Race: Which one or more of the following is your race? (Check all that apply. Do not leave blank.)
☐ White ☐ Filipino ☐ Guamanian or Chamorro
☐ Black or African American ☐ Japanese ☐ Samoan
☐ American Indian or Alaska Native (specify tribe(s))_____ ☐ Korean ☐ Vietnamese ☐ Other Asian (specify)_____ ☐ Native Hawaiian ☐ Other Pacific Islander (specify)_____ ☐ Other (specify)_____ ☐ Unknown
☐ Asian Indian
☐ Chinese

MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy?
☐ Yes ☐ No

Height ft.____in.____ Weight (Pre-pregnancy) lbs. _____

Cigarettes Smoked Per Day ☐ Check if none
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 go into labor planning to deliver at home or at 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

LEGAL RELATIONSHIP OF PARENTS

Did you have a legal spouse or Oregon Registered Domestic (same sex) Partner at conception, at delivery, or within 300 days prior to delivery? ☐ Yes ☐ **NO**
If so, were you married? ☐ Yes ☐ **NO**
If not married, were you in an Oregon Registered Domestic (same sex) Partnership? ☐ Yes ☐ **NO**
Will father/second parent information be provided? ☐ Yes ☐ **NO**

Last revised May 2017

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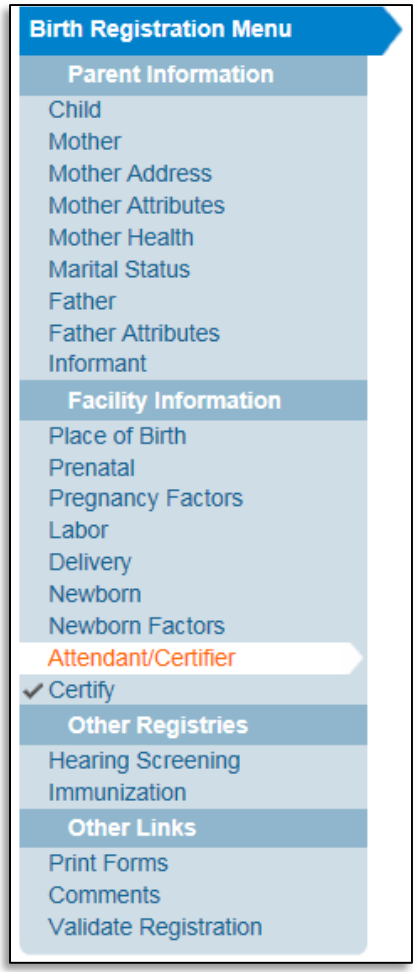
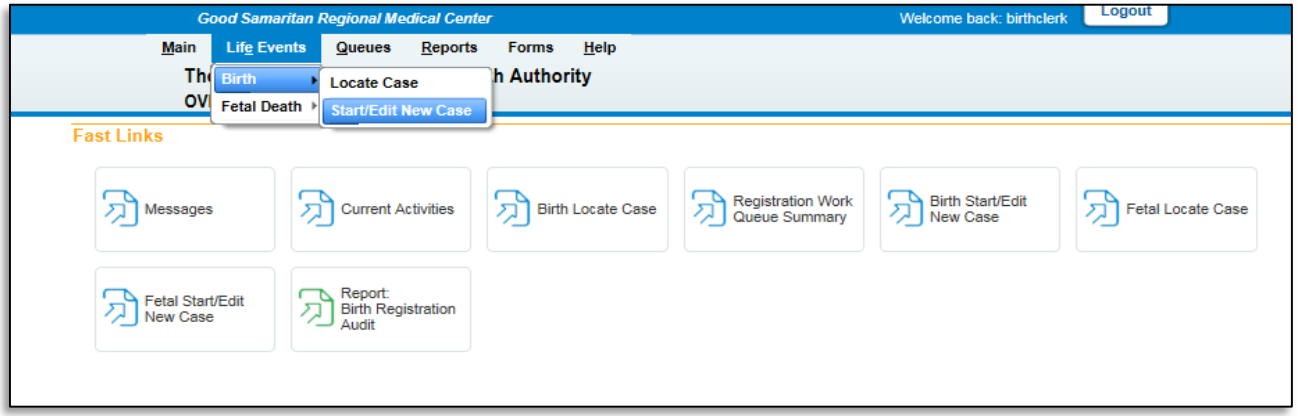
The
Oregon Vital Events
Registration System

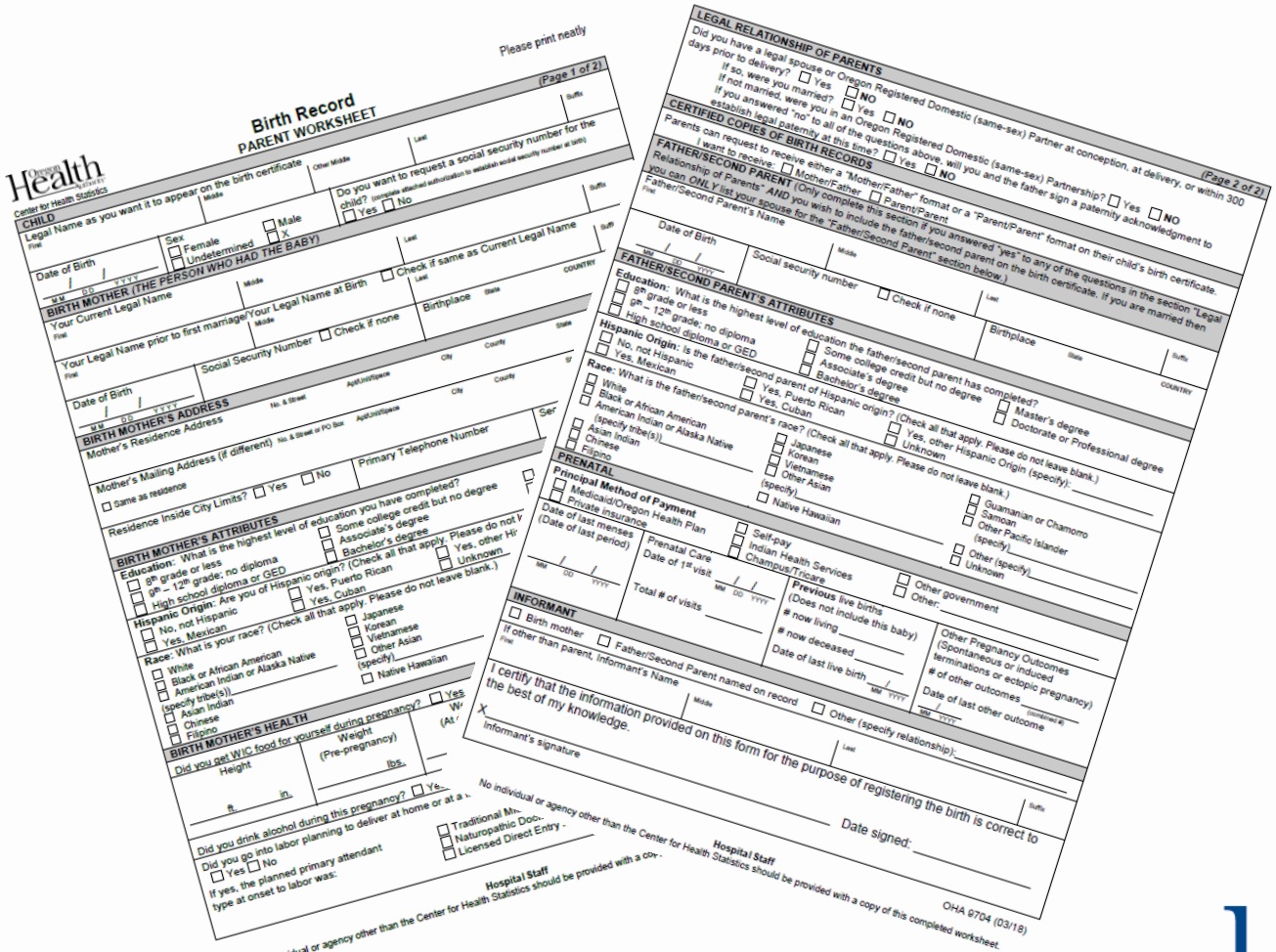
The Basics


Birth Registration Menu
Parent Information
Child
Mother
Mother Address
Mother Attributes
Mother Health
Marital Status
Father
Father Attributes
Informant
Facility Information
Place of Birth
Prenatal
Pregnancy Factors
Labor
Delivery
Newborn
Newborn Factors
Attendant/Certifier
Certify
Other Registries
Hearing Screening
Immunization
Other Links
Print Forms
Comments
Validate Registration


Good Samaritan Regional Medical Center
Welcome back: birthclerk
Logout
Main
Life Events
Queues
Reports
Forms
Help
Birth
Fetal Death
Locate Case
Start/Edit New Case
Fast Links
Messages
Current Activities
Birth Locate Case
Registration Work Queue Summary
Birth Start/Edit New Case
Fetal Locate Case
Fetal Start/Edit New Case
Report: Birth Registration Audit


Validate Page
Next
Clear
Save
Return

Using the Birth Record Parent Worksheet to create a record in OVERS



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Pay close attention to names, sex designation and dates!

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Center for Health Statistics

Birth Record
PARENT WORKSHEET

Please print neatly

CHILD *(Page 1 of 2)*

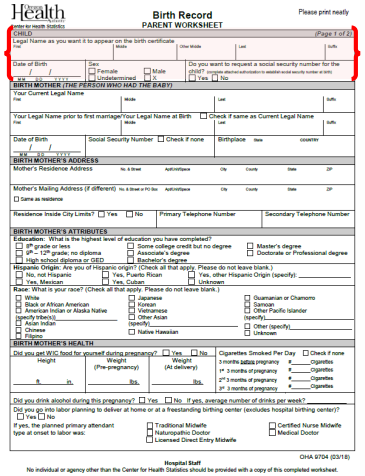
Legal Name as you want it to appear on the birth certificate

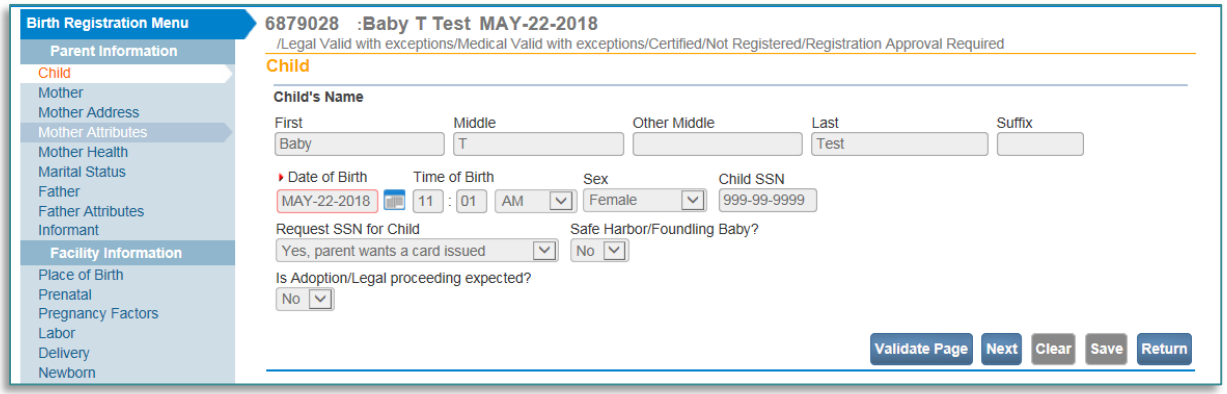
First	Middle	Other Middle	Last	Suffix

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





Don’t forget to add the mother's name prior to first marriage.

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

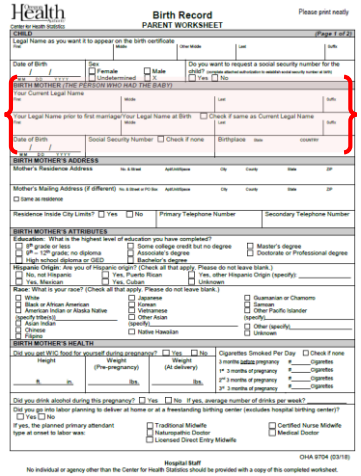
Your Current Legal Name

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	Social Security Number ☐ Check if none	Birthplace State COUNTRY
/ / MM DD YYYY		


Oregon Health Authority

Birth Record
PARENT WORKSHEET

Please print neatly

(Page 1 of 2)

CHILD

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

Date of Birth | Sex: ☐ Female ☐ Male ☐ Undetermined | Do you want to request a social security number for the child? ☐ 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 | 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

BIRTH MOTHER'S ATTRIBUTES

Education: What is the highest level of education you have completed?
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Hispanic Origin: Are you of Hispanic origin? (Check all that apply. Please do not leave blank.)
☐ No, not Hispanic
☐ Yes, Mexican
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Hispanic Origin (specify): _____
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Race: What is your race? (Check all that apply. Please do not leave blank.)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify tribe(s)): _____
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☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (specify): _____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (specify): _____
☐ Other (specify): _____
☐ Unknown

BIRTH MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy? ☐ Yes ☐ No

Height	Weight (Pre-pregnancy)	Weight (At delivery)	Cigarettes Smoked Per Day ☐ Check if none
ft. in.	lbs.	lbs.	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
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☐ Medical Doctor

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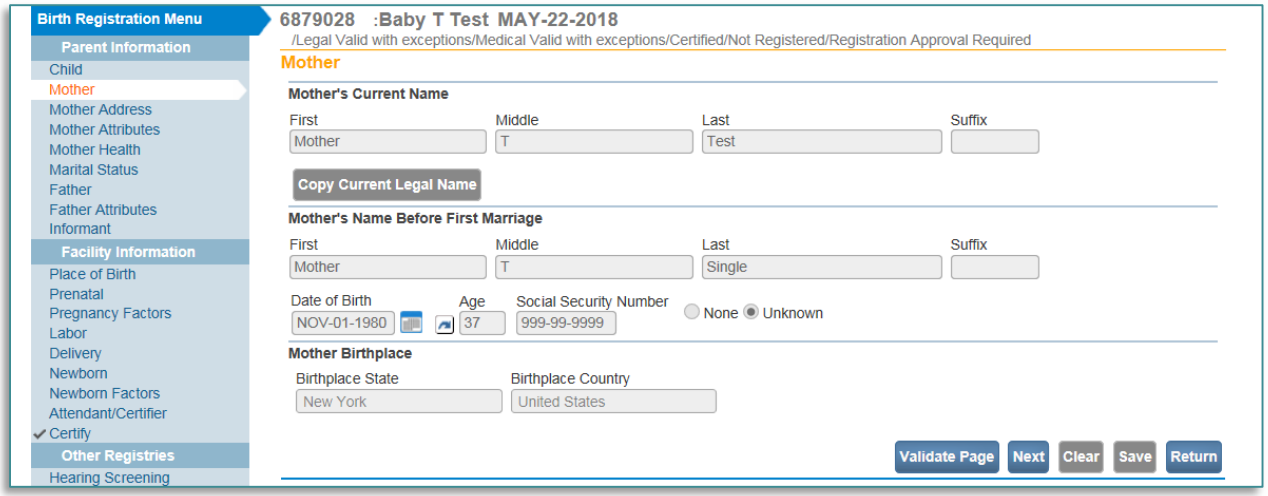

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Remember: “Marital status” applies to the time at birth.

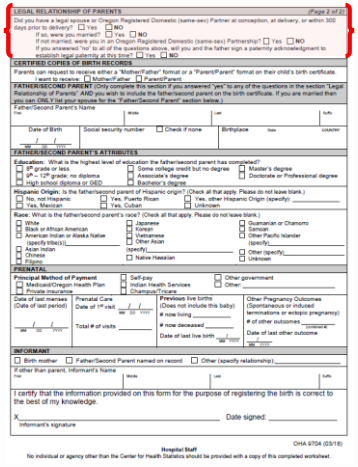
LEGAL RELATIONSHIP OF PARENTS *(Page 2 of 2)*

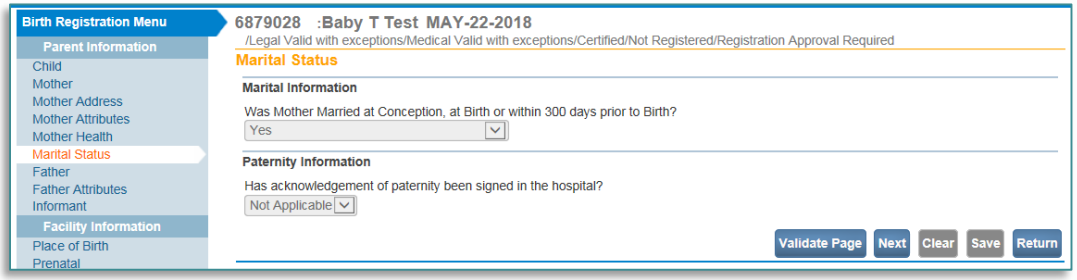
Did you have a legal spouse or Oregon Registered Domestic (same-sex) Partner at conception, at delivery, or within 300 days prior to delivery? ☐ Yes ☐ **NO**

If so, were you married? ☐ Yes ☐ **NO**

If not married, were you in an Oregon Registered Domestic (same-sex) Partnership? ☐ Yes ☐ **NO**

If you answered “no” to all of the questions above, will you and the father sign a paternity acknowledgment to establish legal paternity at this time? ☐ Yes ☐ **NO**





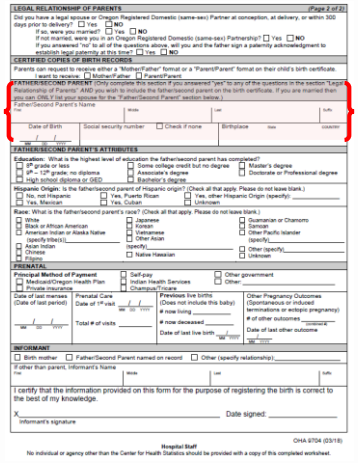
Pay close attention to names, sex designation and dates!

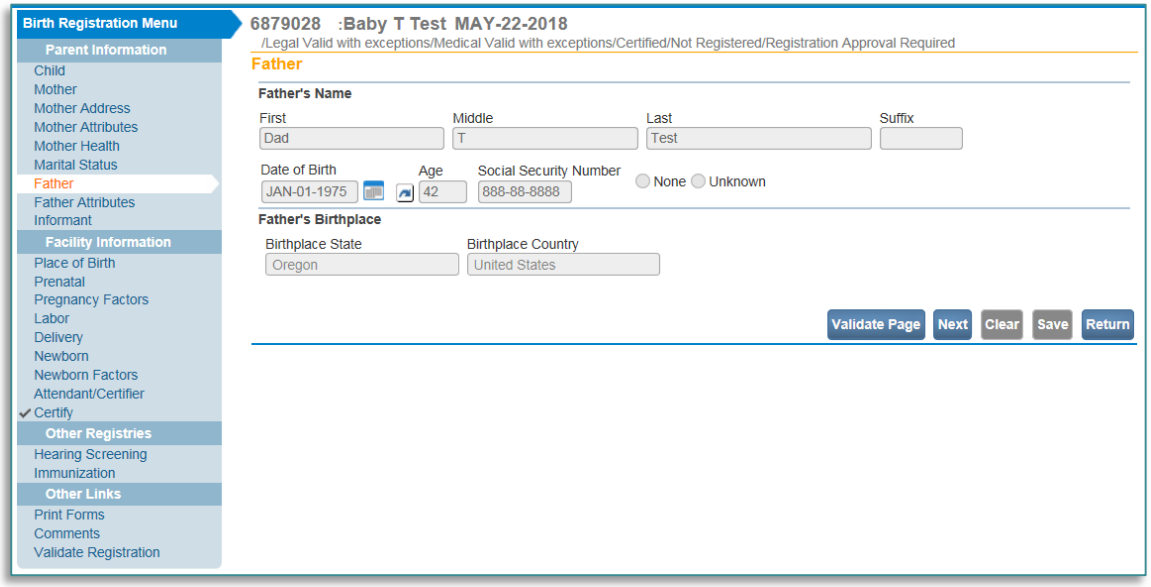
FATHER/SECOND PARENT (Only complete this section if you answered "yes" to any of the questions in the section "Legal Relationship of Parents" ***AND*** you wish to include the father/second parent on the birth certificate. If you are married then you can ***ONLY*** list your spouse for the "Father/Second Parent" section below.)

Father/Second Parent's Name

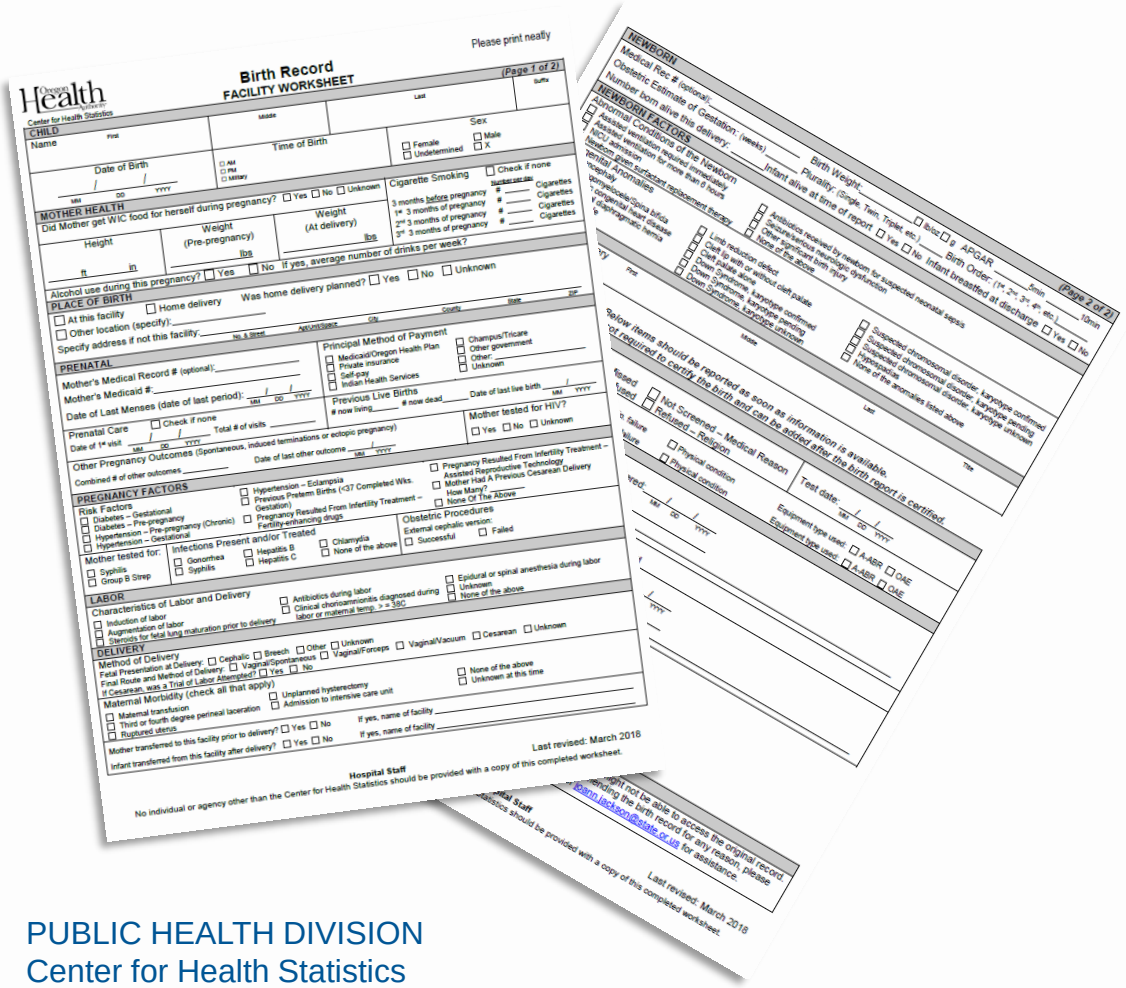
First	Middle	Last	Suffix

Date of Birth	Social security number	☐ Check if none	Birthplace	State	COUNTRY
/ / MM DD YYYY					





Birth Record Facility Worksheet and OVERS



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

Use the guide book for help with definitions.

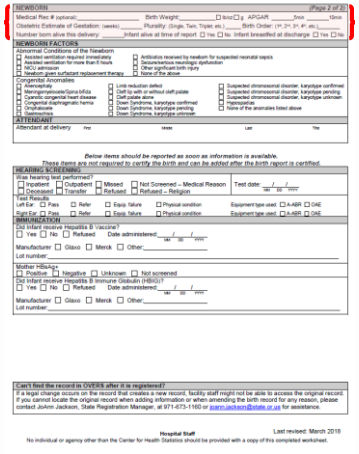
NEWBORN *(Page 2 of 2)*

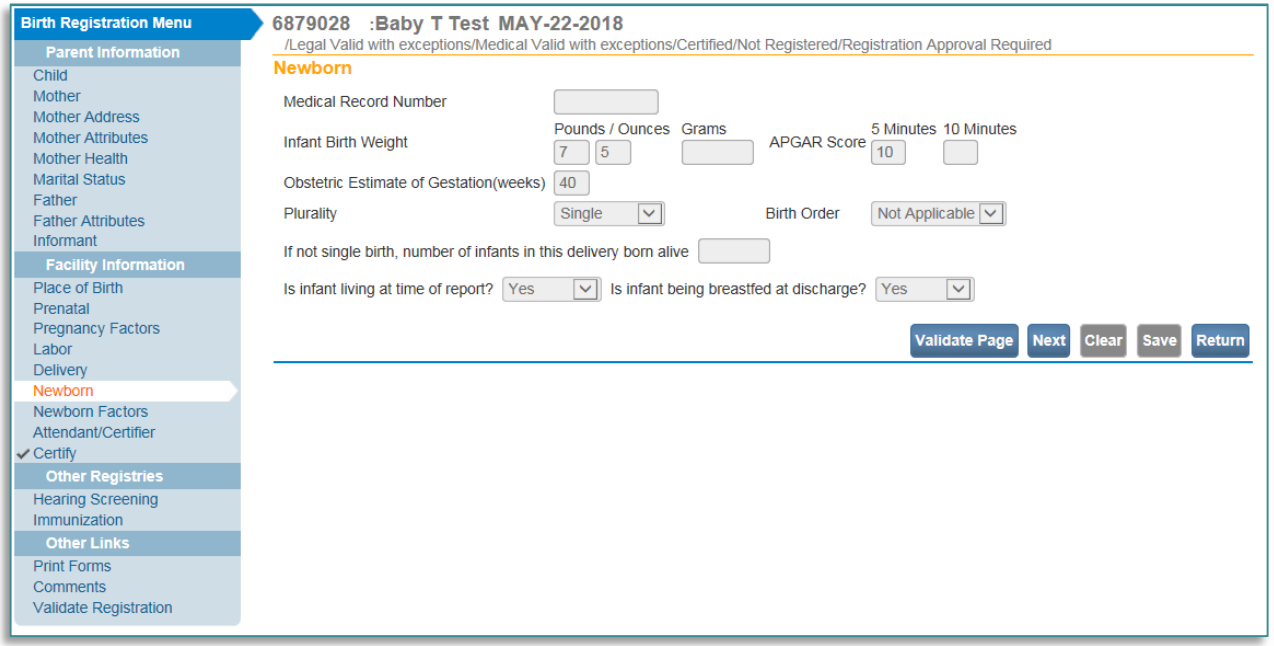
Medical Rec # (optional):_____ Birth Weight:_____ ☐ lb/oz ☐ g APGAR _____5min _____10min

Obstetric Estimate of Gestation: (weeks) _____ Plurality: (Single, Twin, Triplet, etc.) _____ Birth Order: (1st, 2nd, 3rd, 4th, etc.)_____

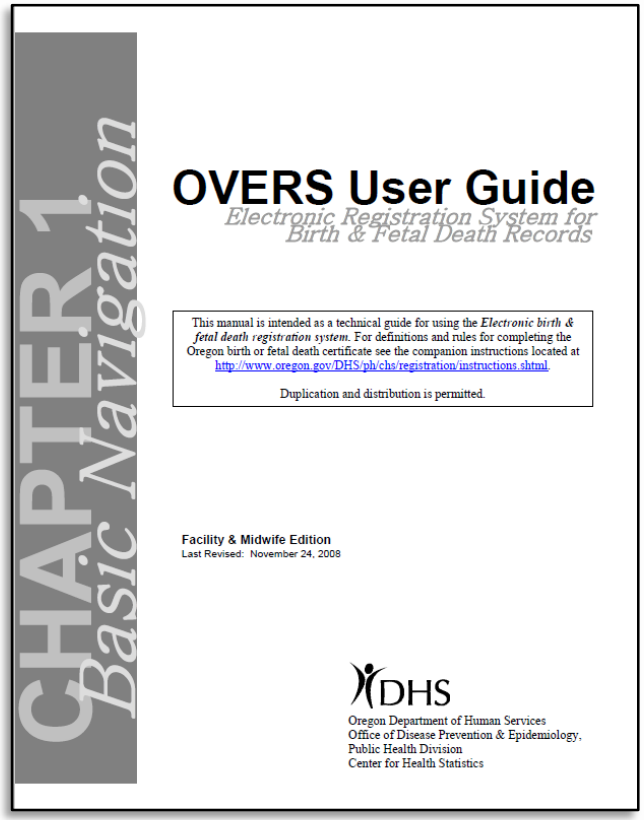
Number born alive this delivery: _____Infant alive at time of report ☐ Yes ☐ No Infant breastfed at discharge ☐ Yes ☐ No

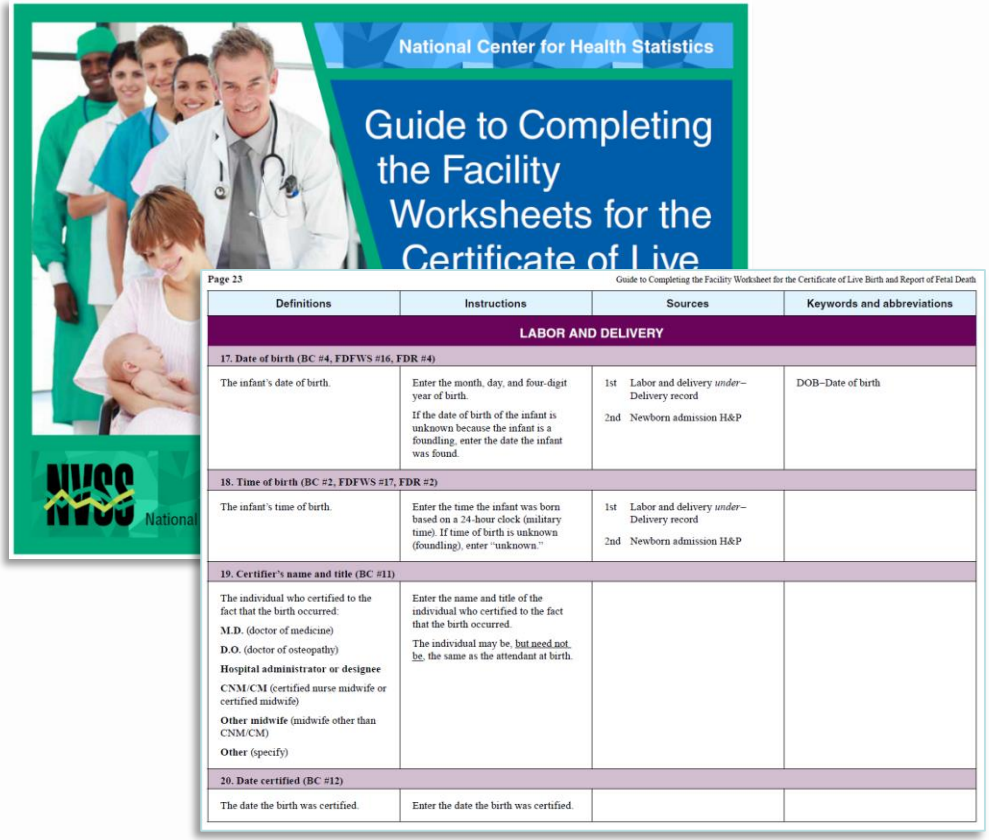
NEWBORN FACTORS





Use the guide book for help with definitions.





Below items should be reported as soon as information is available.
These items are not required to certify the birth and can be added after the birth report is certified.

HEARING SCREENING

Was hearing test performed?

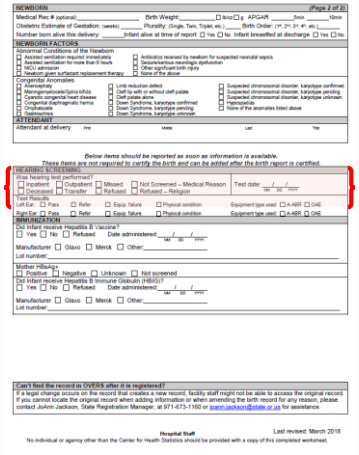
☐ Inpatient ☐ Outpatient ☐ Missed ☐ Not Screened – Medical Reason
☐ Deceased ☐ Transfer ☐ Refused ☐ Refused – Religion

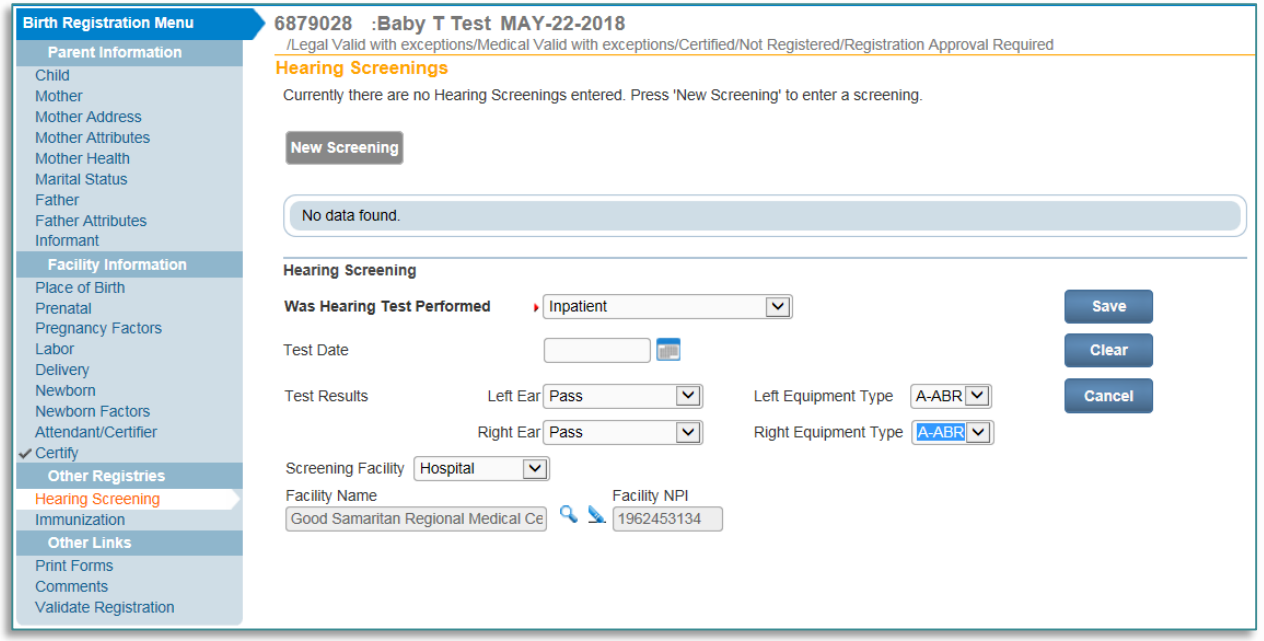
Test date: ___/___/___ (MM DD YYYY)

Test Results

Left Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE

Right Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE





IMMUNIZATION

Did Infant receive Hepatitis B Vaccine?

☐ Yes ☐ No ☐ Refused Date administered: ____/____/____
MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other: _____

Lot number: _____

Mother HBsAg+

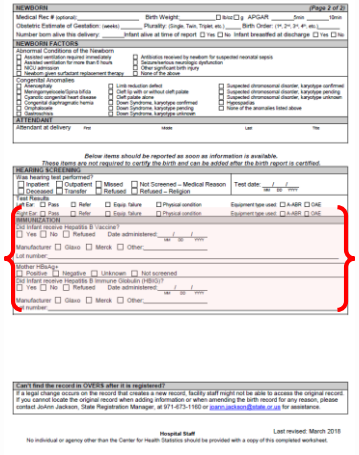
☐ Positive ☐ Negative ☐ Unknown ☐ Not screened

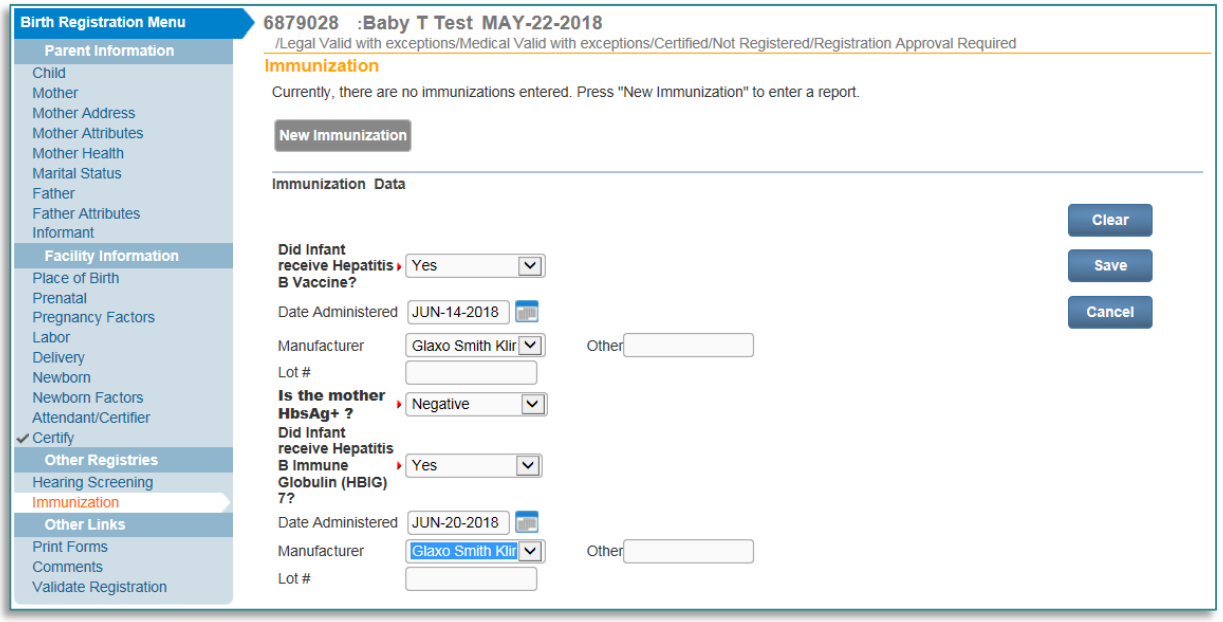
Did Infant receive Hepatitis B Immune Globulin (HBIG)?

☐ Yes ☐ No ☐ Refused Date administered: ____/____/____
MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other: _____

Lot number: _____





Pay attention to…

- Names
- Sex Designations
- Dates
- Hyphens

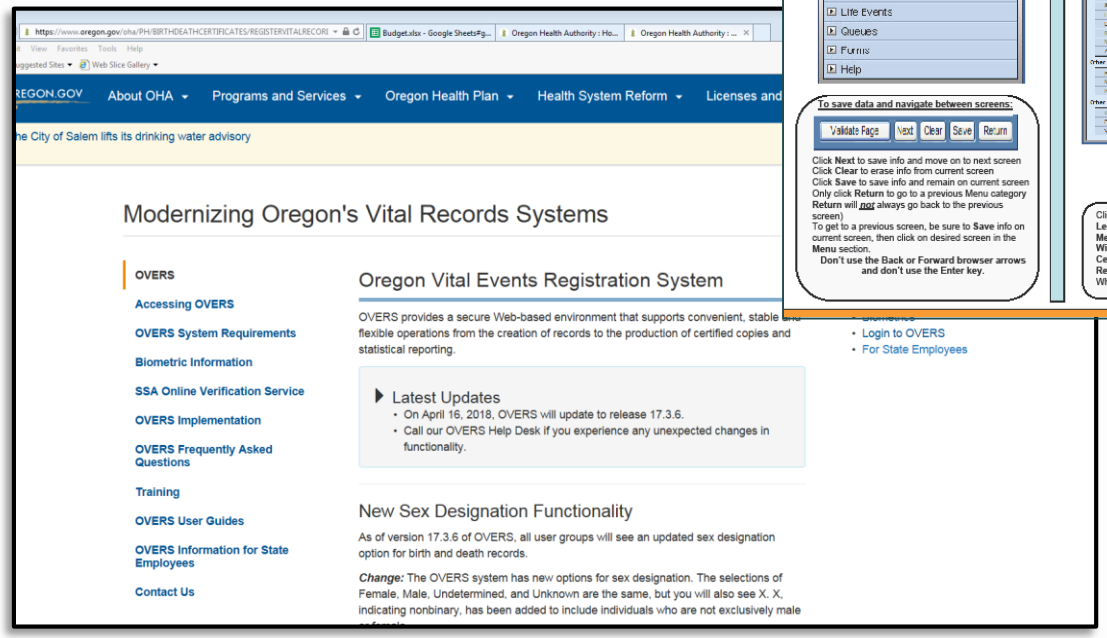
Remember!

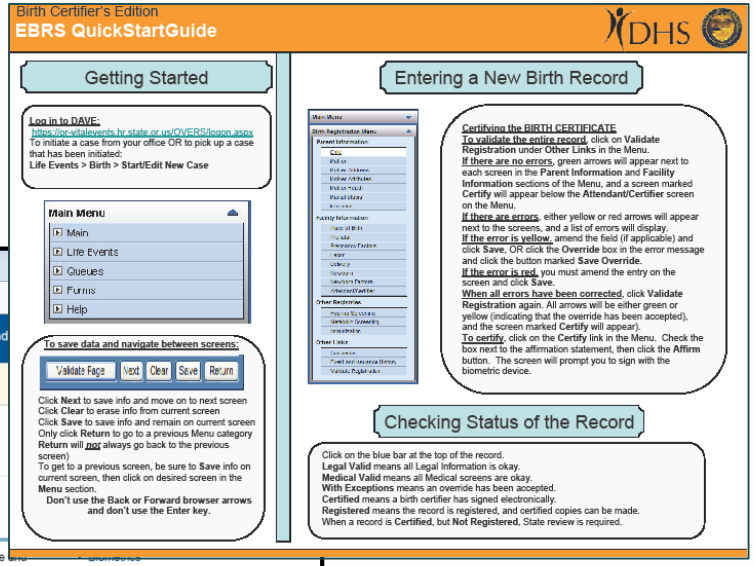
- Entries in OVERS create an official birth record.
- Review your entries for errors.
- Amendments are listed on the certificate permanently.
- Worksheets should inform OVERS entry.

Resources

References

- Quick Reference Guide and User Guides
- Instructions and Worksheets
- Birth Page





Next Steps

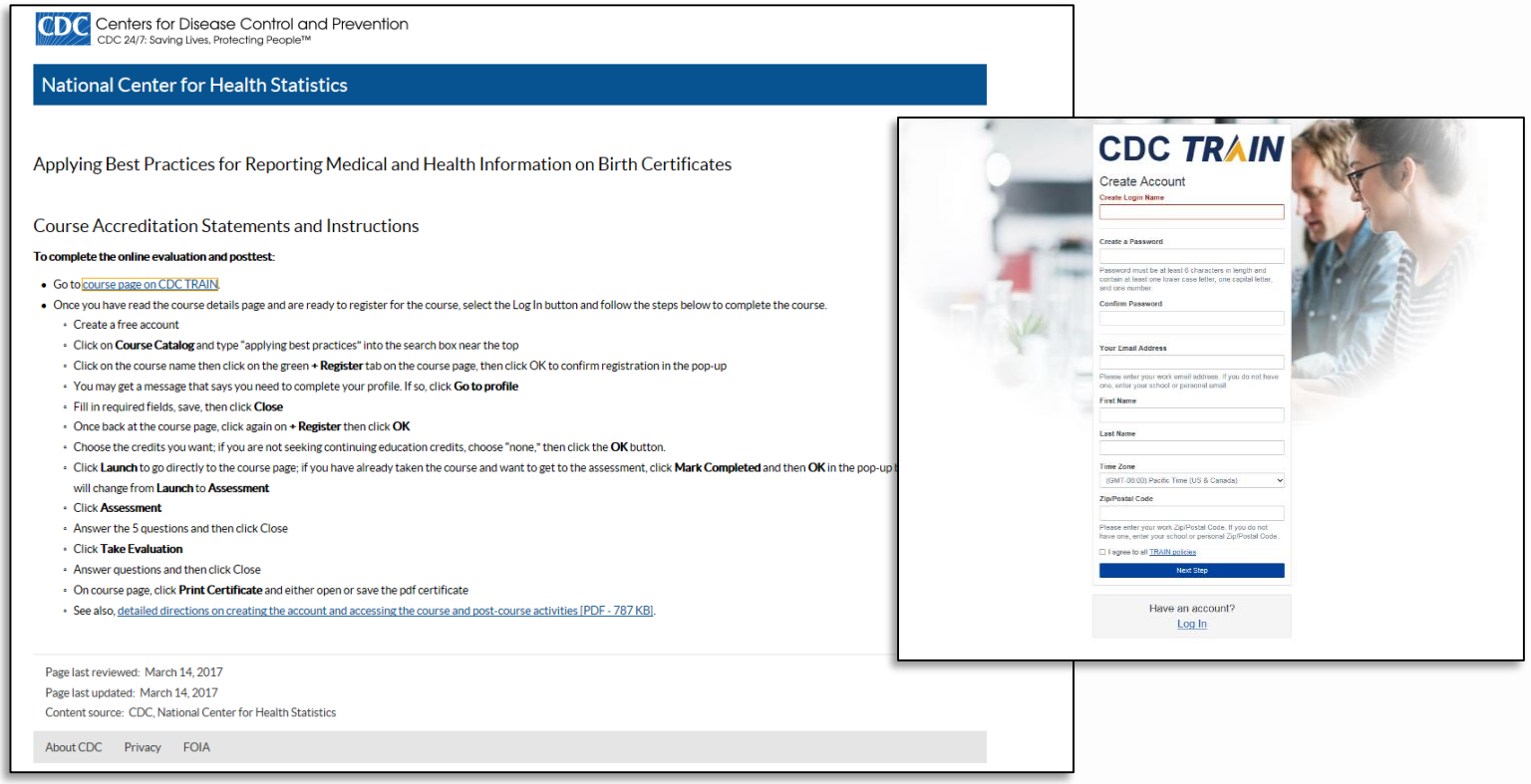
NEXT

Take the new eLearning training found on our website.

“Applying Best Practices for Reporting Medical and Health Information on Birth Certificates”
created by the National Center for Health Statistics (NCHS).

Login to CDC Train and complete your profile.

CDC Birth Training Page



CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

National Center for Health Statistics

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

Course Accreditation Statements and Instructions

To complete the online evaluation and posttest:

- Go to course page on CDC TRAIN.
- Once you have read the course details page and are ready to register for the course, select the Log In button and follow the steps below to complete the course.
  - Create a free account
  - Click on **Course Catalog** and type "applying best practices" into the search box near the top
  - Click on the course name then click on the green **+ Register** tab on the course page, then click OK to confirm registration in the pop-up
  - You may get a message that says you need to complete your profile. If so, click **Go to profile**
  - Fill in required fields, save, then click **Close**
  - Once back at the course page, click again on **+ Register** then click **OK**
  - Choose the credits you want; if you are not seeking continuing education credits, choose "none," then click the **OK** button.
  - Click **Launch** to go directly to the course page; if you have already taken the course and want to get to the assessment, click **Mark Completed** and then **OK** in the pop-up
    will change from **Launch** to **Assessment**
  - Click **Assessment**
  - Answer the 5 questions and then click Close
  - Click **Take Evaluation**
  - Answer questions and then click Close
  - On course page, click **Print Certificate** and either open or save the pdf certificate
  - See also, detailed directions on creating the account and accessing the course and post-course activities [PDF - 787 KB].

Page last reviewed: March 14, 2017
Page last updated: March 14, 2017
Content source: CDC, National Center for Health Statistics

About CDC Privacy FOIA

CDC TRAIN

Create Account

Create Login Name

Create a Password

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

Your Email Address

Please enter your work email address. If you do not have one, enter your school or personal email.

First Name

Last Name

Time Zone

(GMT-08:00) Pacific Time (US & Canada)

Zip/Postal Code

Please enter your work Zip/Postal Code. If you do not have one, enter your school or personal Zip/Postal Code.

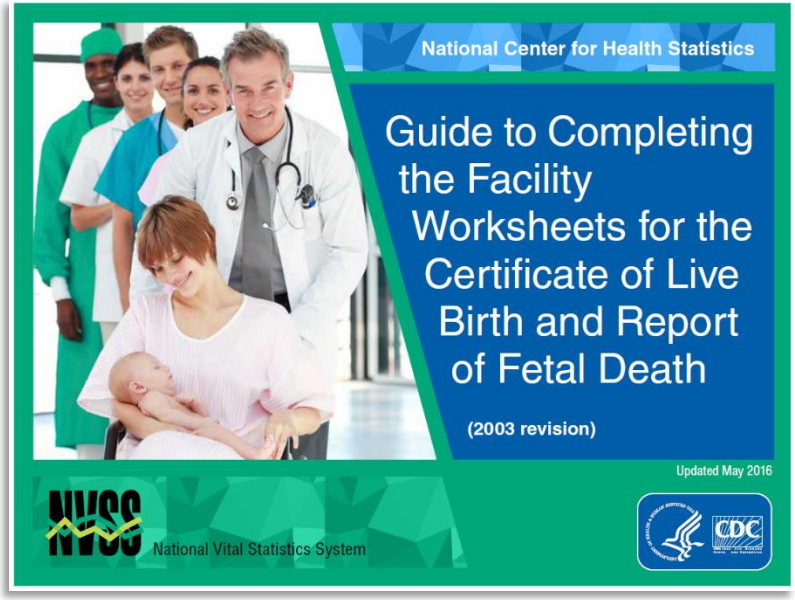
I agree to all TRAIN policies

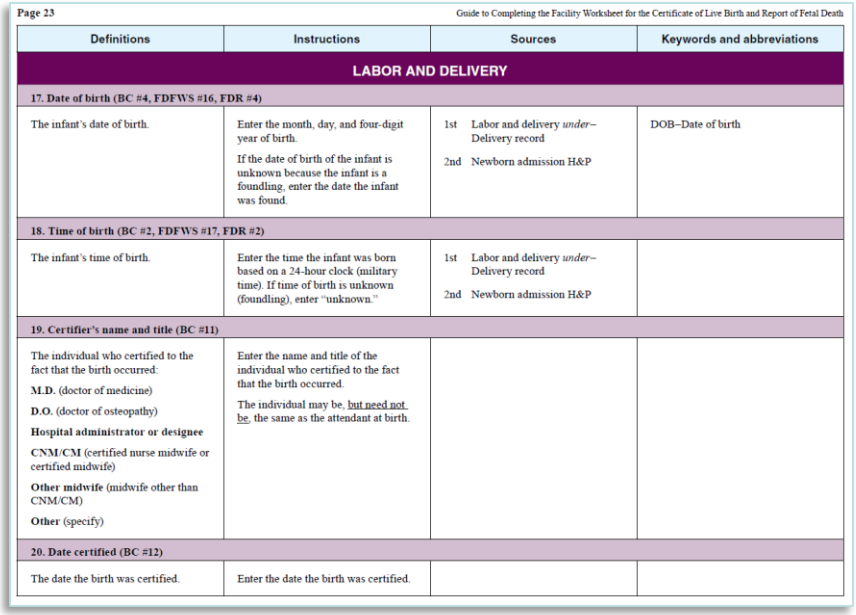
Next Step

Have an account?
Log In

Review the guide found on the CDC website.

“Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death”





Page 23 — Guide to Completing the Facility Worksheet for the Certificate of Live Birth and Report of Fetal Death

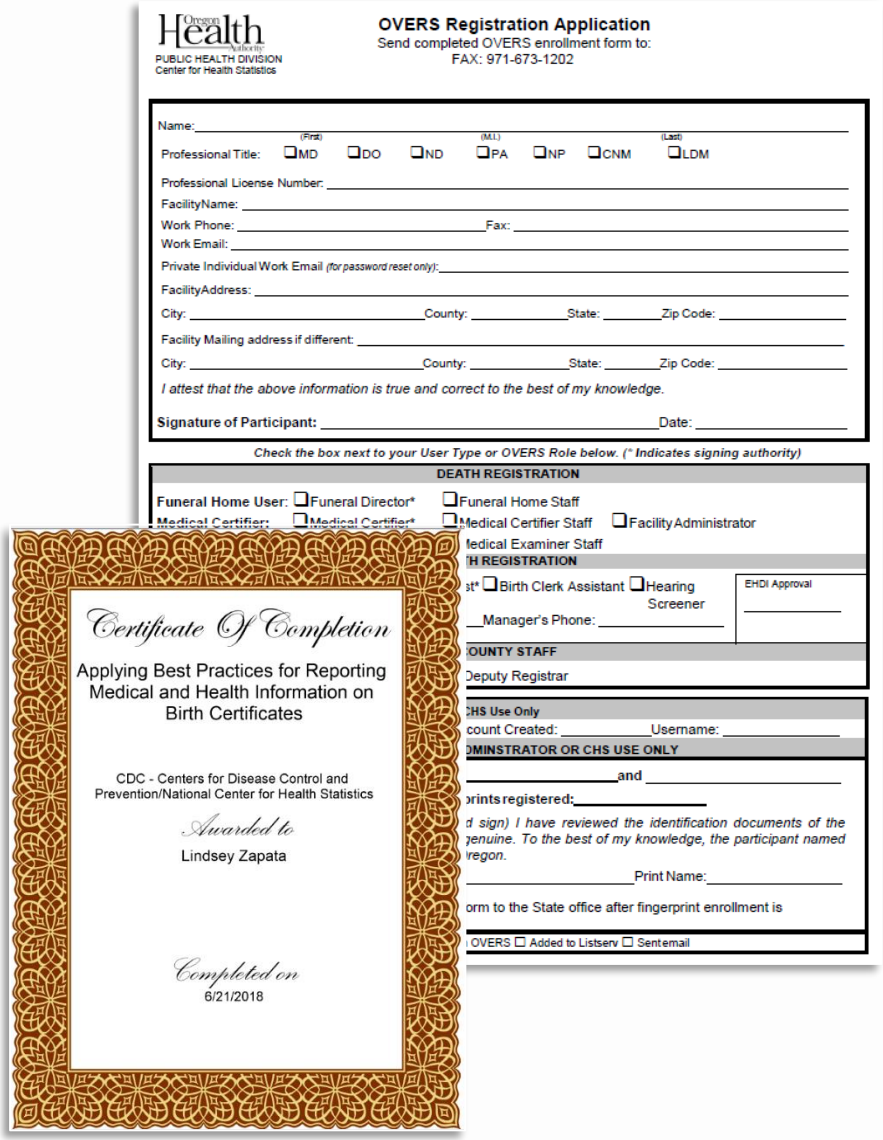
Definitions	Instructions	Sources	Keywords and abbreviations
LABOR AND DELIVERY			
17. Date of birth (BC #4, FDFWS #16, FDR #4)			
The infant's date of birth.	Enter the month, day, and four-digit year of birth. If the date of birth of the infant is unknown because the infant is a foundling, enter the date the infant was found.	1st Labor and delivery *under–* Delivery record 2nd Newborn admission H&P	DOB–Date of birth
18. Time of birth (BC #2, FDFWS #17, FDR #2)			
The infant's time of birth.	Enter the time the infant was born based on a 24-hour clock (military time). If time of birth is unknown (foundling), enter "unknown."	1st Labor and delivery *under–* Delivery record 2nd Newborn admission H&P	
19. Certifier's name and title (BC #11)			
The individual who certified to the fact that the birth occurred: **M.D.** (doctor of medicine) **D.O.** (doctor of osteopathy) **Hospital administrator or designee** **CNM/CM** (certified nurse midwife or certified midwife) **Other midwife** (midwife other than CNM/CM) **Other** (specify)	Enter the name and title of the individual who certified to the fact that the birth occurred. The individual may be, but need not be, the same as the attendant at birth.		
20. Date certified (BC #12)			
The date the birth was certified.	Enter the date the birth was certified.		

How to register in OVERS:

Send the following completed documentation to Megan Welter MEGAN.L.WELTER@dhsoha.state.or.us

1.) OVERS enrollment form
2.) CDC training certificate
3.) confirmation of attendance at this webinar (Sent by Lindsey)

OVERS Enrollment Form Page



Oregon Health Authority
PUBLIC HEALTH DIVISION
Center for Health Statistics

OVERS Registration Application
Send completed OVERS enrollment form to:
FAX: 971-673-1202

Name: (First) (M.I.) (Last)
Professional Title: ☐MD ☐DO ☐ND ☐PA ☐NP ☐CNM ☐LDM
Professional License Number:
Facility Name:
Work Phone: Fax:
Work Email:
Private Individual Work Email *(for password reset only)*:
Facility Address:
City: County: State: Zip Code:
Facility Mailing address if different:
City: County: State: Zip Code:
I attest that the above information is true and correct to the best of my knowledge.
Signature of Participant: Date:

Check the box next to your User Type or OVERS Role below. (Indicates signing authority)*

DEATH REGISTRATION
Funeral Home User: ☐Funeral Director* ☐Funeral Home Staff
Medical Certifier: ☐Medical Certifier* ☐Medical Certifier Staff ☐Facility Administrator
☐Medical Examiner Staff

H REGISTRATION
st* ☐Birth Clerk Assistant ☐Hearing Screener
EHDI Approval
Manager's Phone:

OUNTY STAFF
Deputy Registrar

HS Use Only
count Created: Username:

OMINSTRATOR OR CHS USE ONLY
and
rints registered:
d sign) I have reviewed the identification documents of the genuine. To the best of my knowledge, the participant named regon.
Print Name:
orm to the State office after fingerprint enrollment is
OVERS ☐ Added to Listserv ☐ Sentemail

Certificate Of Completion

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

CDC - Centers for Disease Control and Prevention/National Center for Health Statistics

Awarded to

Lindsey Zapata

Completed on

6/21/2018

Oregon Health Authority

Upcoming Opportunity!

Birth Information Specialist Workgroup Reconvening

- Meets quarterly for process improvement and system development.
- Contact Lindsey at lindsey.m.Zapata@state.or.us for more info.

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