
Birth Information Specialist and Midwife Training 2024



Training Requirement

- ❑ 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

- ❑ 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

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.

Laws, policies and procedures

Highlights of the laws and policies

- ❑ 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

- ❑ 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 (2021 Edition)

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 (2021 Edition)

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]

***In 2022,
39,388*
births
occurred in
Oregon
*2022
preliminary data***

PUBLIC HEALTH DIVISION
Center for Health Statistics



99%

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

How are birth records completed?

1. Birth Information Specialists or Midwives gather information from parents and medical record.
2. Information is entered into OVERTS.
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

- ❑ 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

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

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

CHILD		Page 1 of 5	
1. Legal Name as you want it to appear on the birth certificate			
First	Middle	Other Middle	Last
2. Date of Birth			
3. Sex			
4. Do you want to request a social security number for the child?			
BIRTH MOTHER (THE PERSON WHO HAD THE BABY)			
5. Your Current Legal Name			
6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth			
7. Date of Birth			
8. Social Security Number			
9. Birthplace			
BIRTH MOTHER'S ADDRESS			
10. Mother's Residence Address			
11. Mother's Mailing Address (if different)			
12. Residence Inside City Limits?			
13. Primary Telephone Number			
14. Secondary Telephone Number			
BIRTH MOTHER DEMOGRAPHICS			
15. Education: What is the highest level of education you have completed?			
Race or Ethnicity: Complete BOTH questions (16 and 17)			
16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?			
17a. Which of the following describes your racial or ethnic identity? Please check ALL that apply.			
<div> <div> <p>Hispanic and Latin/Latino:</p> <p>Central American</p> <p>Mexican</p> <p>South American</p> <p>Cuban</p> <p>Puerto Rican</p> <p>Other Hispanic or Latino/a</p> <p>Specify:</p> </div> <div> <p>Native Hawaiian and Pacific Islander:</p> <p>Chamorro (Chamorro)</p> <p>Marshallese</p> <p>Communities of the Micronesian Region</p> <p>Native Hawaiian</p> <p>Samoa</p> <p>Other Pacific Islander</p> <p>Specify:</p> </div> <div> <p>White:</p> <p>Eastern European</p> <p>Slavic</p> <p>Western European</p> <p>Other White</p> <p>Specify:</p> </div> </div> <div> <p>American Indian and Alaska Native:</p> <p>American Indian</p> <p>Alaska Native</p> <p>Canadian-Inuit, Metis, or First Nation</p> <p>Indigenous Mexican, Central American, or South American</p> <p>Specify Tribe(s):</p> </div> <div> <p>Black and African American:</p> <p>African American</p> <p>Afro-Caribbean</p> <p>Ethiopian</p> <p>Somali</p> <p>Other African (Black)</p> <p>Specify:</p> <p>Other Black</p> <p>Specify:</p> </div> <div> <p>Middle Eastern/North African:</p> <p>Middle Eastern</p> <p>North Africa</p> </div> <div> <p>Asian:</p> <p>Asian Indian</p> <p>Cambodian</p> <p>Chinese</p> <p>Communities of Myanmar</p> <p>Filipino</p> <p>Hmong</p> <p>Japanese</p> <p>Korean</p> <p>Laotian</p> <p>South Asian</p> <p>Vietnamese</p> <p>Other Asian</p> <p>Specify:</p> <p>Not listed please specify:</p> <p>Opt out options:</p> <p>Don't know</p> <p>Don't want to answer</p> </div>			

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

Facility Worksheet

- 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 Worksheets

- 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 Authority
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
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
Prenatal Care: ☐ Check if none
Date of 1st visit: MM / DD / YYYY Total # of visits: _____
Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy): _____
Combined # of other outcomes: _____ Date of last other outcome: MM / DD / YYYY
Previous Live Births: # now living: _____ # now dead: _____ Date of last live birth: MM / DD / YYYY
Mother tested for HIV? ☐ Yes ☐ No ☐ Unknown

PREGNANCY FACTORS
Risk Factors: ☐ Diabetes - Gestational ☐ Hypertension - Eclampsia ☐ Pregnancy Resulted From Infertility Treatment - Assisted Reproductive Technology
☐ Diabetes - Pre-pregnancy ☐ Previous Preterm Births (<37 Completed Wks. Gestation) ☐ Mother Had A Previous Cesarean Delivery
☐ Hypertension - Pre-pregnancy (Chronic) ☐ Pregnancy Resulted From Infertility Treatment - How Many? _____
☐ Hypertension - Gestational ☐ Fertility-enhancing drugs ☐ None Of The Above

Mother tested for: ☐ Syphilis ☐ Gonorrhea ☐ Hepatitis B ☐ Chlamydia ☐ None of the above
☐ Group B Strep ☐ Syphilis ☐ Hepatitis C ☐ None of the above

OBSTETRIC PROCEDURES
External cephalic version: ☐ Successful ☐ Failed

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

DELIVERY
Method of Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown
Fetal Presentation at Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown
Trial of Labor Attempted? ☐ Yes ☐ No
Cesarean (check all that apply): ☐ Unplanned hysterectomy ☐ None of the above
☐ Degree perineal laceration ☐ Admission to intensive care unit ☐ Unknown at this time
Delivered at this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility: _____
Delivered at this facility after delivery? ☐ Yes ☐ No If yes, name of facility: _____

Hospital Staff
Last revised: March 2018
If 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 / / 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 / / 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

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 ☐ 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 ☐ Certified Nurse Midwife ☐ Naturopathic Doctor ☐ Medical Doctor ☐ Licensed Direct Entry Midwife

Hospital Staff OHA 9704 (03/18)

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

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 / / 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

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 #: ☐ Medicaid/Oregon Health Plan ☐ Champus/Tricare ☐ Private insurance ☐ Other government ☐ Self-pay ☐ Indian Health Services ☐ Other

Date of Last Menses (date of last period): / /

Prenatal Care ☐ Check if none Total # of visits Previous Live Births ☐ now living ☐ now dead Date of last live birth / /

Date of 1st visit / /

DELIVERY

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

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 Morbidity (check all that apply)

☐ Maternal transfusion ☐ Unplanned hysterectomy ☐ None of the above

☐ Third or fourth degree perineal laceration ☐ Admission to intensive care unit ☐ Unknown at this time

☐ Ruptured uterus

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.

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

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

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

Oregon Health
Center for Health Statistics

Voluntary Acknowledgment of Paternity Affidavit

THIS IS A LEGAL DOCUMENT
Fees: \$35 Filing fee
\$25 Birth certificate

This document establishes paternity under ORS 432.088. 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 until you understand your legal rights and responsibilities as stated on the back of this form. Complete in ink and do not alter.

SECTION 1 – CHILD (as named on birth certificate)

Child's name: First Middle Last Suffix (Example: Jr. or Sr.)

Date of birth: (mm/dd/yyyy) Birthplace: City County Child's new last name: (as it should appear on birth certificate)

SECTION 2 – NATURAL MOTHER OF CHILD

Mother's name: First Middle Last Suffix (Example: Jr. or Sr.)

Present address: No. and street City State ZIP Social Security number: - -

Date of birth: (mm/dd/yyyy) Birthplace State: (If not United States, name country) Last name before any marriages: (Maiden name) Daytime telephone number: - -

SECTION 3 – NATURAL FATHER OF CHILD

Father's name: First Middle Last Suffix (Example: Jr. or Sr.)

Present address: No. and street City State ZIP Social Security number: - -

Date of birth: (mm/dd/yyyy) Birthplace State: (If not United States, name country) Daytime telephone number: - -

Oregon Health
PUBLIC HEALTH DIVISION
Center for Health Statistics

Voluntary Acknowledgment of Paternity

THIS IS A LEGAL DOCUMENT

This document establishes paternity under ORS 432.088. 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.

SECTION 1 – Child (as named on birth certificate)

Child's name: First Middle Last Suffix (Example: Jr. or Sr.)

Date of birth: (mm/dd/yyyy): Child's birthplace (hospital or health care facility name):

SECTION 2 – Natural mother of child

Mother's name: First Middle Last Suffix (Example: Jr. or Sr.)

Last name before any marriages (Maiden name): Social Security number: - -

Date of birth: (mm/dd/yyyy): Birthplace State: (If not United States, name country): Daytime telephone number: - -

SECTION 3 – Natural father of child

Father's name: First Middle Last Suffix (Example: Jr. or Sr.)

Present address: No. and Street City State ZIP Social Security number: - -

Date of birth: (mm/dd/yyyy): Birthplace State: (If not United States, name country): Daytime telephone number: - -

SECTION 4 – Witnessed signatures

Read and understand before you sign this document. Do not sign until hospital witness is present.

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.

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) it has 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-caring agency, and have not had my parental rights terminated; 6) I am signing this Acknowledgment for the purpose of establishing paternity of the child.

Do not sign until hospital witness is present.

Mother's printed name: X Mother's signature: Date signed: - -

Hospital witness: printed name: X Hospital witness signature: Date witnessed: - -

Father's printed name: X Father's signature: Date signed: - -

Hospital witness: printed name: X Hospital witness signature: Date witnessed: - -

FOR VITAL RECORDS USE ONLY Date Filed: Per ORS 109.0706, Paternity is established upon filing of this form by the State Registrar of the Center for Health Statistics.

45-31 (01/16)

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

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

...OR

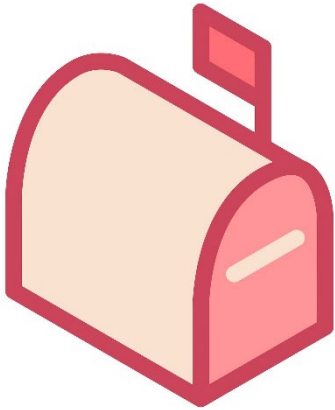
- Send parents home with the Affidavit 45-21 if the parents leave without signing the hospital form
- It must be signed before a notary



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

- ✓ Provide the Voluntary Acknowledgment of Paternity (45-31) 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.
- ✓ Make sure the dates the parents sign match the witness dates.

Submitting the AOP form to the State



- 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.

Want more information on paternity establishment?

[FAQ: Establishing Paternity](#)

[Paternity Forms and Instructions](#)

Responsibilities of Birth Information Specialists: Reporting Fetal Deaths

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 our
Fetal Death
website.

PUBLIC HEALTH DIVISION
Center for Health Statistics

Oregon Health Authority Center for Health Statistics		FETAL DEATH REPORT FACILITY WORKSHEET		Please print neatly	
<p><i>Only use this form to report a Fetal Death</i></p> <p><i>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.</i></p>					
FETUS		Date of Delivery		Time of Delivery	
Fetus Name First Middle Last Suffix		MM / DD / YYYY		AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	
METHOD OF DISPOSITION (Select one)					
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) _____					
MOTHER'S HEALTH		PRENATAL			
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 / DD / YYYY (Does not include this fetus)			
Weight (Pre-pregnancy) lbs _____		# now living _____ # now deceased _____			
1 st 3 months of pregnancy # _____ Cigarettes		No Prenatal Care <input type="checkbox"/> OR Date of 1 st visit MM / DD / YYYY			
2 nd 3 months of pregnancy # _____ Cigarettes					
3 rd 3 months of pregnancy # _____ Cigarettes					
PREGNANCY FACTORS					
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					
DELIVERY					
Method of Delivery					
Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other					
Final Route and Method of Delivery <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> If Cesarean, was a Trial of Labor Attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Maternal Morbidity (check all that apply) <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> None of the above					
Mother Transferred for maternal or fetal indication prior to delivery <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____					
FETAL ATTRIBUTES					
Weight of Fetus _____		Obstetric Estimate of Gestation (weeks) _____		Plurality (Single, Twin, Triplet, etc.) _____	
<input type="checkbox"/> lb/oz <input type="checkbox"/> grams				Delivery Order (1 st , 2 nd , 3 rd , 4 th , etc.) _____	
CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH					
Initiating Cause/Conditioning (enter one condition or cause only)					
Maternal Conditions/Disease (specify) _____					
Complications of placenta, cord or membranes:					
<input type="checkbox"/> Rupture of membranes <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Rupture of membranes <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Abruption placenta <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Abruption placenta <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Other <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Other					
Other obstetrical or pregnancy complications(specify) _____					
Fetal Anomaly (specify) _____					
Fetal Injury(specify) _____					
Fetal Infection (specify) _____					
Other fetal conditions/disorders (specify) _____					
<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 _____					

Last revised December 2018

Oregon Health Authority

The Oregon Vital Events Registration System (OVERS)

A brief introduction and live demonstration

VISION

Birth Record Facility Worksheet and OVERTS

Please print neatly

Birth Record FACILITY WORKSHEET (Page 1 of 2)

CHILD
Name _____ Sex ☐ Male ☐ Female

Date of Birth _____ Time of Birth _____

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

Height _____ Weight (Pre-pregnancy) _____ Weight (At delivery) _____

Alcohol use during this pregnancy? ☐ Yes ☐ No ☐ Unknown

PLACE OF BIRTH
☐ At this facility ☐ Home delivery ☐ Was home delivery planned? ☐ Yes ☐ No ☐ Unknown

PRENATAL
Mother's Medical Record # (optional): _____
Date of Last Menstrual Period (date of last period): _____
Prenatal Care _____
Other Pregnancy Outcomes (Spontaneous, induced, terminated or ectopic pregnancy): _____

PREGNANCY FACTORS
Risk Factors: ☐ Diabetes - Gestational ☐ Diabetes - Pre-pregnancy ☐ Hypertension - Gestational ☐ Hypertension - Pre-pregnancy (Chronic) ☐ Infections Present and/or Treated: ☐ Gonorrhea ☐ Syphilis ☐ Hepatitis B ☐ Hepatitis C ☐ Chlamydia ☐ None of the above

LABOR
Characteristics of Labor and Delivery: ☐ Induction of labor ☐ Augmentation of labor ☐ Anesthetics for fetal long maturation prior to delivery ☐ Antibiotics during labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > 38.0°C ☐ Epistaxis or spinal anesthesia during labor ☐ None of the above

DELIVERY
Method of Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown

POSTNATAL
Apgar 1 _____ Apgar 5 _____
Birth Weight _____
Placenta: ☐ Placenta examined by newborn for suspected neonatal sepsis ☐ Placenta not examined

REPORTING
Reported as soon as information is available _____
The birth can be added after the birth report is certified _____

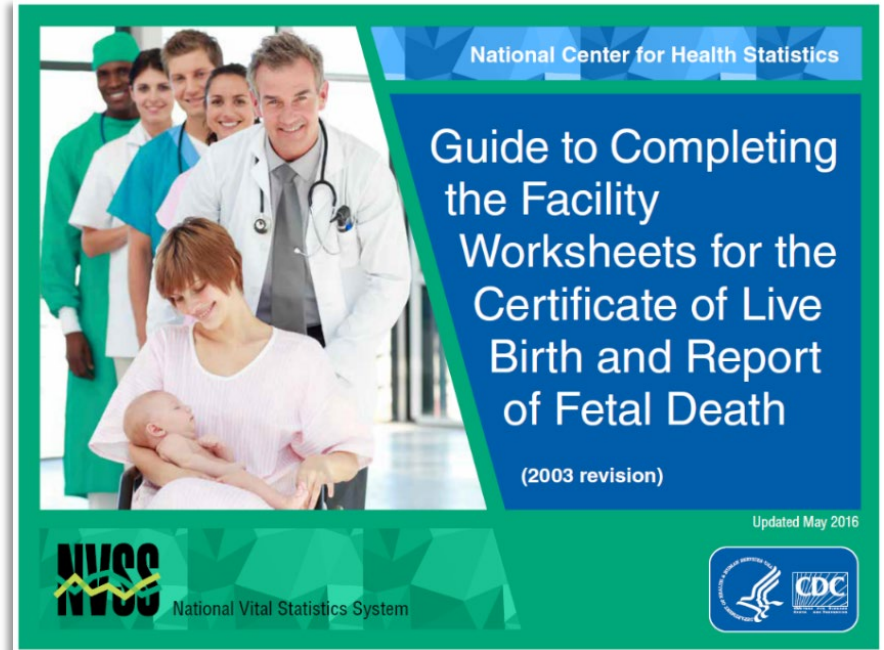
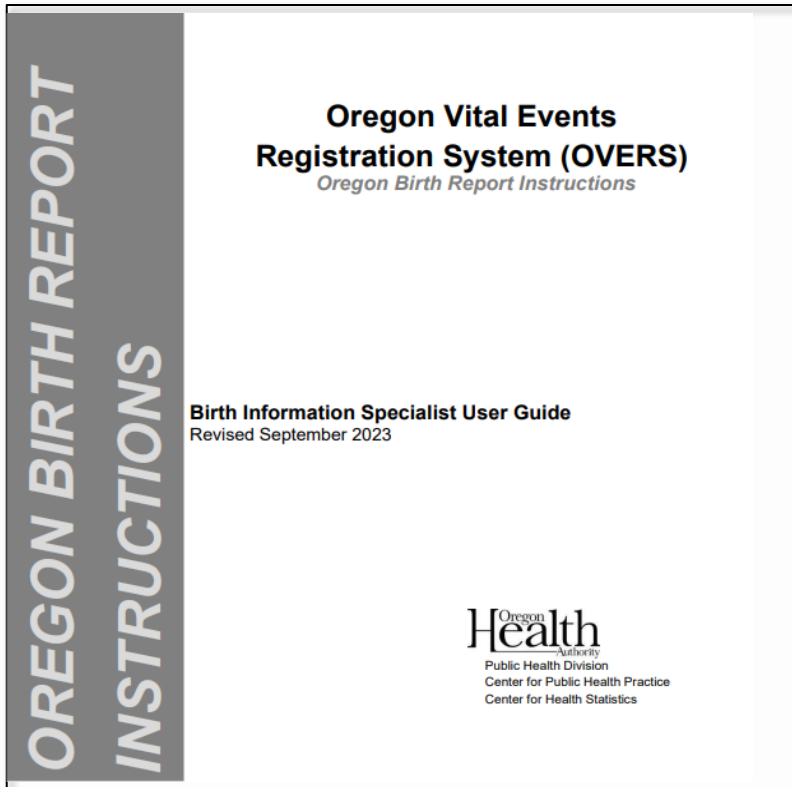
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

Last revised: March 2018

- 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.



Watch the OVERS Demonstration Tutorial

[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

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.

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

NEXT

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](#).

 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 box. Green box 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-05:00) 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 [CDC TRAIN policies](#)

Next Step

Have an account? [Log In](#)

Print the certificate for the Applying Best Practices for Reporting Medical and Health Information on Birth Certificates course.

- 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). *CE certificates are not issued within TRAIN.* In order to receive CE for this course, click the "Get CE" button below and follow the [9 Simple Steps](#) before June 25, 2025.

Get CE

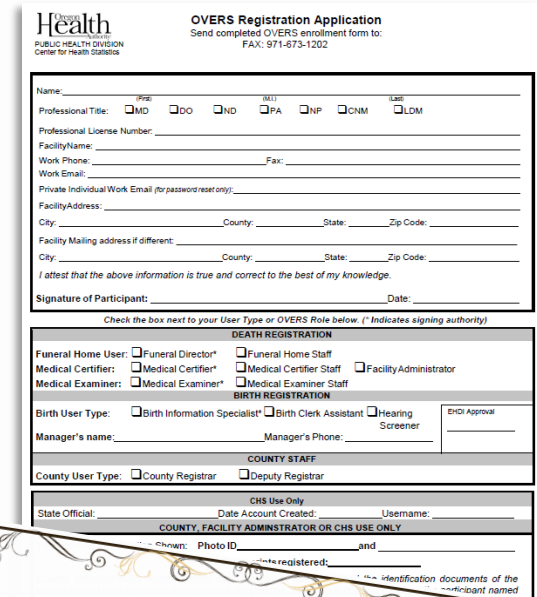
What is needed for an OVERS account

To complete your enrollment in OVERS

Fax the following completed documentation to 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 form is titled "OVERS Registration Application" and is from the Oregon Health Authority, Public Health Division, Center for Health Statistics. It includes fields for Name, Professional Title (with checkboxes for MD, DO, ND, PA, NP, CNM, LDM), Professional License Number, Facility Name, Work Phone, Fax, Work Email, Private Individual Work Email (password reset only), Facility Address, City, County, State, and Zip Code. It also has a section for Facility Mailing address if different. A signature line for the participant is at the bottom. Below the signature line, there are checkboxes for "Check the box next to your User Type or OVERS Role below." and "DEATH REGISTRATION" (Funeral Home User, Medical Certifier, Medical Examiner, Funeral Home Staff, Medical Certifier Staff, Facility Administrator, Medical Examiner Staff). There is also a "BIRTH REGISTRATION" section with checkboxes for Birth User Type (Birth Information Specialist, Birth Clerk Assistant, Hearing Screener) and Manager's name/phone. A "COUNTY STAFF" section has checkboxes for County User Type (County Registrar, Deputy Registrar). A "CHS Use Only" section has fields for State Official, Date Account Created, Username, and Password. A "COUNTY, FACILITY ADMINISTRATOR OR CHS USE ONLY" section has fields for County, Photo ID, and Date registered. A note at the bottom right says "The identification documents of the participant named".



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.

The screenshot shows the 'Birth Registration Menu' with two main sections: 'Parent Information' and 'Facility Information'. Under 'Parent Information', there is a 'Child' section followed by 'Mother' and 'Father' sections, each with sub-items like 'Demographics', 'Disability', 'Health', 'Marital Status', and 'Informant'. Under 'Facility Information', there is a 'Place of Birth' section followed by 'Prenatal', 'Labor', 'Delivery', 'Newborn', and 'Attendant/Certifier' sections.

Site Navigation

- [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.

The screenshot shows the 'Facility Information' section with a list of items: 'Place of Birth', 'Prenatal', 'Pregnancy Factors', 'Labor', 'Delivery', 'Newborn', 'Newborn Factors', 'Attendant/Certifier', and 'Certify'. The 'Certify' link is circled in red.

The screenshot shows the 'Oregon Vital Events Registration System' website. The header includes 'MODERNIZING OREGON'S VITAL RECORDS SYSTEMS'. The main content area is divided into three columns: 'OVERS' (with links like 'Accessing OVERS', 'OVERS System Requirements', 'Biometric Information', 'OVERS Online Verification Service', 'OVERS Implementation', 'OVERS Frequently Asked Questions', 'Training', 'OVERS User Guides', 'OVERS Information for State Employees', and 'Contact Us'), 'Oregon Vital Events Registration System' (with text about the secure Web-based environment and 'Latest Updates' from April 16, 2018), and 'More Information' (with links for 'Biometrics', 'Login to OVERS', and 'For State Employees'). A 'New Sex Designation Functionality' section is also visible at the bottom.

Contacts

Kathy Ellis
Vital Records Trainer
971-673-1353
Kathy.Ellis@oha.oregon.gov

Karen Rangan
Partner Services Manager
971-673-1160
Karen.L.Rangan@oha.oregon.gov

Johanna Collins
Amendments Manager
Johann.D.Collins@oha.oregon.gov
971-673-1178

Karen Rangan
Partner Services Manager
971-673-1160
Karen.L.Rangan@oha.oregon.gov

Marsha Trump
Systems, Records Management &
Statistics Manager
971-673-1191
Marsha.Trump@oha.oregon.gov



971-673-0279

PUBLIC HEALTH DIVISION
Center for Health Statistics

Oregon
Health
Authority