
Birth Information Specialist and Midwife Training 2020

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font positioned above the "H" of the word "Health". The word "Health" is in a large, dark blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right edge of the "Authority" text.

Oregon
Health
Authority

Training requirement

- This training is required to file Oregon birth records and to use OVERS.
- If you are currently filing Oregon birth records and using OVERS, this training must be completed by June 30, 2020.
- If you are a new BIS or Midwife needing to file Oregon birth records and use OVERS, this training must be completed before you will 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 NCHS
- ❑ Contacts and resources

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, 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.
- ❑ Birth 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 (2017 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 (2017 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 2019,
42,288
births
occurred in
Oregon*



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 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

- ❑ There are two worksheets used to collect the information for 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 and in the US.

- ❑ 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 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.
- Sign the worksheet.

Oregon Health
Center for Health Statistics

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 X
M M D D Y Y Y Y

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
M M D D Y Y Y Y

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

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

BIRTH MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy? Yes No Cigarettes Smoked Per Day Check if none
Height Weight Weight 3 months before pregnancy # Cigarettes
ft. in. (Pre-pregnancy) (At delivery) 1st 3 months of pregnancy # Cigarettes
lbs. lbs. 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.

Parent Worksheet

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

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 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

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

Height ft _____ in _____	Weight (Pre-pregnancy) lbs _____	Weight (At delivery) lbs _____	3 months before pregnancy # _____ Cigarettes
			1 st 3 months of pregnancy # _____ Cigarettes
			2 nd 3 months of pregnancy # _____ Cigarettes
			3 rd 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): _____ Principal Method of Payment

Mother's Medicaid #: _____ Medicaid/Oregon Health Plan Champus/Tricare

Private insurance Other government

Date of Last Menses (date of last period): MM / DD / YYYY Self-pay Other: _____

Indian Health Services Unknown

Prenatal Care Check if none Previous Live Births

Date of 1st visit MM / DD / YYYY Total # of visits _____ # now living _____ # now dead _____ Date of last live birth MM / YYYY

Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy) Mother tested for HIV?

Combined # of other outcomes _____ Date of last other outcome MM / YYYY Yes No Unknown

PREGNANCY FACTORS

<input type="checkbox"/> Risk Factors	<input type="checkbox"/> Hypertension - Eclampsia	<input type="checkbox"/> Pregnancy Resulted From Infertility Treatment - Assisted Reproductive Technology
<input type="checkbox"/> Diabetes - Gestational	<input type="checkbox"/> Previous Preterm Births (<37 Completed Wks. Gestation)	<input type="checkbox"/> Mother Had A Previous Cesarean Delivery
<input type="checkbox"/> Diabetes - Pre-pregnancy	<input type="checkbox"/> Hypertension - Gestational	<input type="checkbox"/> How Many?
<input type="checkbox"/> Hypertension - Pre-pregnancy (Chronic)	<input type="checkbox"/> Pregnancy Resulted From Infertility Treatment - Fertility-enhancing drugs	<input type="checkbox"/> None Of The Above

Mother tested for: Syphilis Gonorrhea Syphilis Infections Present and/or Treated: Hepatitis B Chlamydia 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

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 None of the above

Free perineal laceration Admission to intensive care unit Unknown at this time

Was this facility prior to delivery? Yes No If yes, name of facility _____

Was this facility after delivery? Yes No If yes, name of facility _____

Hospital Staff _____ Last revised: March 2018

Agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

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

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
Do you want to request a social security number for the child? (Requires 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: First Middle Last
Your Legal Name at Birth: First Middle Last
 Check if same as Current Legal Name

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 Some college credit but no degree Master's degree
 9th - 12th grade; no diploma Associate's degree Doctorate or Professional degree

1) Parent Worksheet:

Completed by the parent(s)

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

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.

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

MOTHER HEALTH

Did Mother get WIC food for herself during pregnancy? Yes No Unknown
Cigarette Smoking: 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

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

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: # 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: Hypertension - Eclampsia Previous Preterm Births (<37 Completed Wks.) Pregnancy Resulted From Infertility Treatment - Assisted Reproductive Technology
 Diabetes - Gestational Ruptured uterus Unknown at this time

Admission to intensive care unit: Yes No
If yes, name of facility: _____

Mother transferred to this facility prior to delivery? Yes No
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)

Oregon Health
Center for Health Statistics

Voluntary Acknowledgment of Paternity Affidavit

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

This document establishes paternity under ORS 432.098. 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.) **CSP USE ONLY**

Date of birth: (mm/dd/yyyy) Birthplace

Oregon Health
PUBLIC HEALTH DIVISION
Center for Health Statistics

Voluntary Acknowledgment of Paternity
THIS IS A LEGAL DOCUMENT

This document establishes paternity under ORS 432.098. 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.) **HOSPITAL USE ONLY**
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 _____ Mother's signature _____ Date signed _____
Hospital witness printed name _____ Hospital witness signature _____ Date witnessed _____
Father's printed name _____ Father's signature _____ Date signed _____
Hospital witness printed name _____ Hospital witness signature _____ Date witnessed _____

Name of hospital/clinic _____ City _____
FOR VITAL RECORDS USE ONLY Date filed _____ Fee ORS 469.078(4). Paternity is established upon filing of this form by the State Registrar of the Center for Health Statistics.

45-31 (01/16)

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

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



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

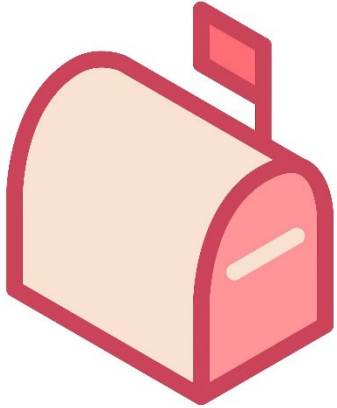
- Send parents home with the Affidavit 45-21 if the parents leave without signing the hospital form
- It must be signed before a notary



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.
- ✓ 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](#)

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.

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.

For more information specific to Fetal Death

Visit our [Fetal Death website.](#)

Oregon Health Authority Center for Health Statistics		FETAL DEATH REPORT FACILITY WORKSHEET		Please print neatly	
<i>Only use this form to report a Fetal Death</i>					
<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>					
FETUS					
Fetus Name First Middle Last Suffix			Date of Delivery MM / DD / YYYY	Time of Delivery AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/>	Sex <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 _____ / _____ / _____		
Height _____ Cigarettes Smoked Per Day _____			Previous Live Births _____ / _____ (Does not include this fetus)		
Weight (Pre-pregnancy) _____			# now living _____ # now deceased _____		
1 st 3 months of pregnancy # _____ Cigarettes			No Prenatal Care <input type="checkbox"/> OR Date of 1 st visit _____ / _____ / _____		
2 nd 3 months of pregnancy # _____ Cigarettes					
3 rd 3 months of pregnancy # _____ Cigarettes					
PREPREGNANCY 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			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
Final Route and Method of Delivery <input type="checkbox"/> Vaginal/Spontaneous					<input type="checkbox"/> Admission to intensive care unit
<input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean					<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.) _____	Delivery Order (1 st , 2 nd , 3 rd , 4 th , etc.) _____
<input type="checkbox"/> lb/oz <input type="checkbox"/> grams					
CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH					
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"/> Rupture of membranes	
<input type="checkbox"/> Abruptio placenta		<input type="checkbox"/> Chorioamnionitis		<input type="checkbox"/> Abruptio placenta	
<input type="checkbox"/> Placental insufficiency		<input type="checkbox"/> Other		<input type="checkbox"/> Placental insufficiency	
<input type="checkbox"/> Other obstetrical or pregnancy complications(specify) _____				<input type="checkbox"/> 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

Use the Birth Record Parent Worksheet to create a record in OVERTS

Please print neatly

Birth Record PARENT WORKSHEET (Page 1 of 2)

Center for Health Statistics

CHILD
Legal Name as you want it to appear on the birth certificate
Date of Birth
Sex
Do you want to request a social security number for the child?
Other Middle
Last
Middle
First
Last
Middle
First

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)
Your Current Legal Name
Your Legal Name prior to first marriage
Your Legal Name at Birth
Check if same as Current Legal Name
Social Security Number
Check if none
Date of Birth
Birthplace
State
County

BIRTH MOTHER'S ADDRESS
Mother's Residence Address
Mother's Mailing Address (if different)
Residence Inside City Limits?
Primary Telephone Number

BIRTH MOTHER'S ATTRIBUTES
Education: What is the highest level of education you have completed?
Hispanic Origin: Are you of Hispanic origin?
Race: What is your race?
Principal Method of Payment
Date of last menses
Prenatal Care
Total # of visits
Previous live births
now living
now deceased
Date of last live birth
Other Pregnancy Outcomes
of other outcomes
Date of last other outcome

BIRTH MOTHER'S HEALTH
Did you get WIC food for yourself during pregnancy?
Did you drink alcohol during this pregnancy?
Did you go into labor planning to deliver at home?
If yes, the planned primary attendant type at onset to labor was:

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?
If so, were you married?
If not married, were you in an Oregon Registered Domestic (same-sex) Partnership?
You can ONLY list your spouse for the "Father/Second Parent" section below.

CERTIFIED COPIES OF BIRTH RECORDS
Parents can request to receive either a "Mother/Father" format or a "Parent/Parent" format on their child's birth certificate. I want to receive:
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 ATTRIBUTES
Education: What is the highest level of education the father/second parent has completed?
Hispanic Origin: Is the father/second parent of Hispanic origin?
Race: What is the father/second parent's race?
Principal Method of Payment
Date of last menses
Prenatal Care
Total # of visits
Previous live births
now living
now deceased
Date of last live birth
Other Pregnancy Outcomes
of other outcomes
Date of last other outcome

PRENATAL
Medical/Oregon Health Plan
Self-pay
Indian Health Services
Champus/TCare
Other government
Other (specify relationship):

INFORMANT
If other than parent, Informant's Name
I certify that the information provided on this form for the purpose of registering the birth is correct to the best of my knowledge.
Informant's signature
Hospital Staff
Date signed:

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

OHA 6704 (03/18)

Birth Record Facility Worksheet and OVERTS

Birth Record FACILITY WORKSHEET (Page 1 of 2)

CHILD
 Name: _____ Sex: Male Female
 Date of Birth: ____/____/____ Time of Birth: ____:____:____
 Cigarette Smoking: Yes No Unknown

MOTHER HEALTH
 Did Mother get WIC food for herself during pregnancy? Yes No Unknown
 Height: ____ ft ____ in Weight (Pre-pregnancy): ____ lbs Weight (At delivery): ____ lbs
 Alcohol use during this pregnancy? Yes No Unknown
 Was home delivery planned? Yes No Unknown

PLACE OF BIRTH
 At this facility Home delivery
 Specify address if not this facility: _____

PRENATAL
 Mother's Medical Record # (optional): _____
 Date of Last Menstrual (date of last period): ____/____/____
 Prenatal Care: Check if none Total # of visits: ____
 Date of 1st visit: ____/____/____

PREGNANCY FACTORS
 Risk Factors: Diabetes - Gestational Hypertension - Gestational Infections Present and/or Treated
 Mother tested for: Syphilis Gonorrhea Hepatitis B Hepatitis C

LABOR
 Characteristics of Labor and Delivery: Induction of labor Augmentation of labor Anesthetics for fetal lung maturation prior to delivery

DELIVERY
 Method of Delivery: Cephalic Breech Other Unknown
 Fetal Presentation at Delivery: Vaginal/Forceps Vaginal/Vacuum Cesarean Unknown

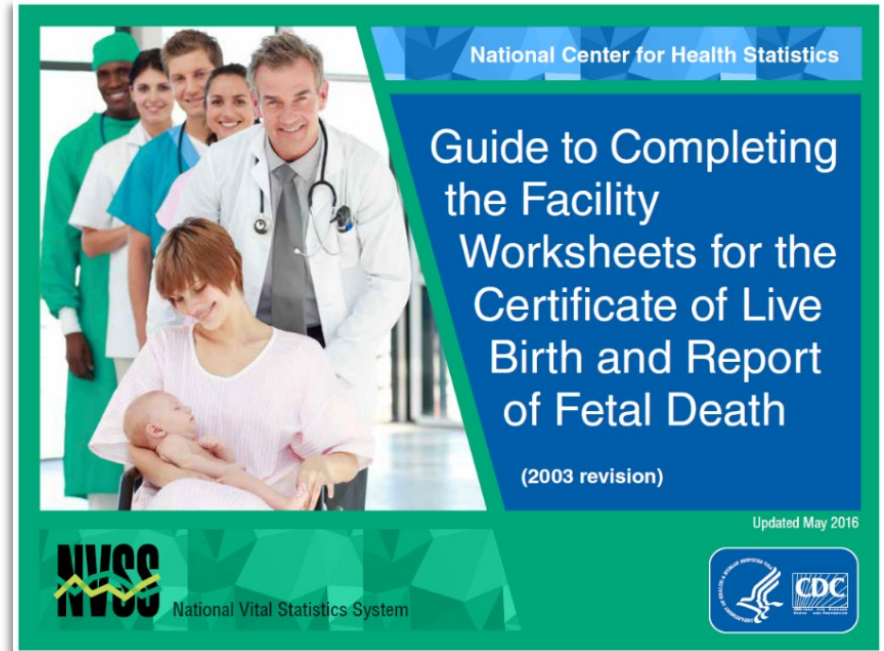
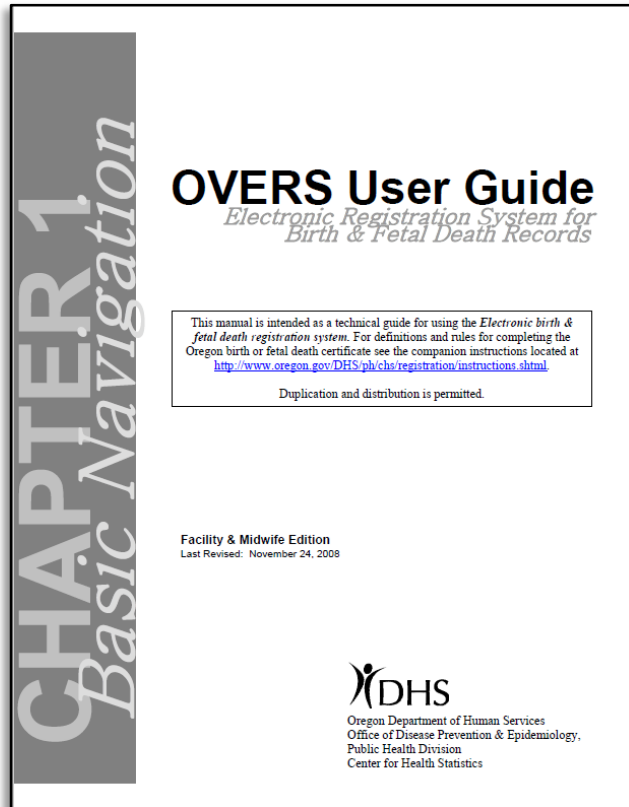
NEWBORN
 Medical Rec # (optional): _____
 Obstetric Estimate of Gestation (weeks): _____ Birth Weight: _____
 Number born alive this delivery: _____ Infant alive at time of report: Yes No

NEWBORN FACTORS
 Anomalous Consonant used for the Newborn
 Assisted ventilation required for more than 6 hours
 Assisted ventilation for more than 6 hours
 Birth asphyxia
 Birth trauma
 Birth injury
 Birth injury
 Birth injury
 Birth injury

- 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 here to watch and listen to the OVERS Demonstration Webinar](#)



- Learn how to enter a case
- Sign in with biometric
- Look through the website for resources

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.

NEXT


Take the required eLearning training:

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



Create an 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 [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

Confirm Password

Your Email Address

First Name

Last Name

Time Zone

Zip/Postal Code

Next Step

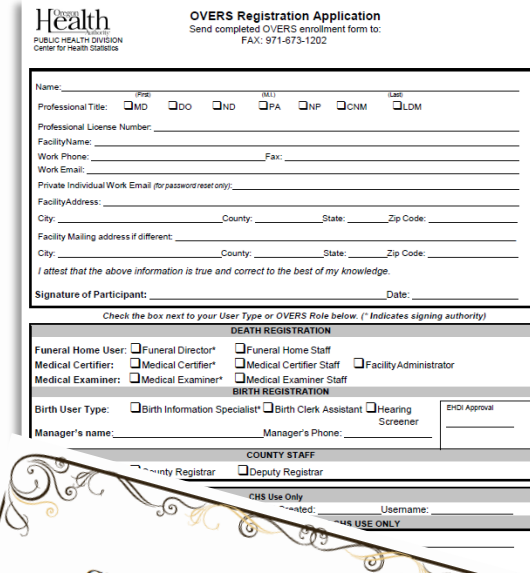
Have an account? [Log In](#)

NEW Birth Information Specialists

Send the following completed documentation to Kathy Ellis:
Kathy.Ellis@state.or.us

1. [OVERS Enrollment Form](#)
2. [OVERS Training Certificate](#)
3. Fax the OVERS Enrollment Form, CDC and OVERS training certificates to 971-673-1202

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



The image shows a form titled "OVERS Registration Application" from the Oregon Health Authority, Public Health Division, Center for Health Statistics. The form includes fields for Name, Professional Title (with checkboxes for MD, DO, ND, PA, NP, CNM, LDM), Professional License Number, Facility Name, Work Phone, Work Email, Private Individual Work Email, Facility Address, City, County, State, and Zip Code. It also has a section for "DEATH REGISTRATION" with checkboxes for Funeral Home User, Medical Certifier, and Medical Examiner, and a "BIRTH REGISTRATION" section with checkboxes for Birth User Type and Manager's name. There are also checkboxes for County Staff (Registrar, Deputy Registrar) and a "CHS Use Only" section for Username and Password.



Current OVERS users

Send your [OVERS Training Certificate](#) and CDC Certificate to Kathy Ellis at Kathy.Ellis@state.or.us or by FAX 971-673-1202 by September 30, 2020.

Once Kathy receives the documentation, you will be authorized to continue to complete birth records and use OVERS after Sept. 30, 2020.



The image shows a form titled "OVERS Registration Application" from the Oregon Health Authority, Public Health Division, Center for Health Statistics. The form includes fields for Name (First, Middle, 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, and Zip Code. It also has a section for "DEATH REGISTRATION" with checkboxes for Funeral Home User, Medical Certifier, and Medical Examiner, and a section for "BIRTH REGISTRATION" with checkboxes for Birth Information Specialist, Birth Clerk Assistant, and Hearing Screener. There is a "COUNTY STAFF" section for Registrar. A signature line and date are provided at the bottom.



CHS Resources

❑ [Quick Start Guide](#)

❑ [Instructions and Worksheets](#)

❑ [Birth Page](#)

Getting Started

Log in to DAVE:
<https://or.vitalrecords.hr.state.or.us/OVERS/looon.aspx>
 To initiate a case from your office OR to pick up a case that has been initiated:
 Life Events > Birth > Start/Edit New Case

Main Menu

- Main
- Life Events
- Queues
- Furnish
- Help

To save data and navigate between screens:

Validate Page Next Clear Save Return

Click Next to save info and move on to next screen
 Click Clear to erase info from current screen
 Click Save to save info and remain on current screen
 Only click Return to go to a previous Menu category
 Return will **not** always go back to the previous screen
 To get to a previous screen, be sure to Save info on current screen, then click on desired screen in the Menu section.
 Don't use the Back or Forward browser arrows and don't use the Enter key.

Entering a New Birth Record

Certifying the BIRTH CERTIFICATE
 To validate the entire record, click on Validate Registration under Other Links in the Menu.
 If there are **no errors**, green arrows will appear next to each screen in the Parent Information and Facility Information sections of the Menu, and a screen marked Certify will appear below the Attendant/Certifier screen on the Menu.
 If there are **errors**, either yellow or red arrows will appear next to the screens, and a list of errors will display.
 If the error is **yellow**, amend the field (if applicable) and click Save, OR click the Override box in the error message and click the button marked Save Override.
 If the error is **red**, you must amend the entry on the screen and click Save.
 When all errors have been corrected, click Validate Registration again. All arrows will be either green or yellow (indicating that the override has been accepted), and the screen marked Certify will appear.
 To **certify**, click on the Certify link in the Menu. Check the box next to the affirmation statement, then click the Affirm button. The screen will prompt you to sign with the biometric device.

Checking Status of the Record

Click on the blue bar at the top of the record.
 Legal Valid means all Legal Information is okay.
 Medical Valid means all Medical screens are okay.
 With Exceptions means an override has been accepted.
 Certified means a birth certifier has signed electronically.
 Registered means the record is registered, and certified copies can be made.
 When a record is Certified, but Not Registered, State review is required.

Modernizing Oregon's Vital Records Systems

OVERS

- Accessing OVERS
- OVERS System Requirements
- Biometric Information
- SSA Online Verification Service
- OVERS Implementation
- OVERS Frequently Asked Questions
- Training
- OVERS User Guides
- OVERS Information for State Employees
- Contact Us

Oregon Vital Events Registration System

OVERS provides a secure Web-based environment that supports convenient, stable and flexible operations from the creation of records to the production of certified copies and statistical reporting.

Latest Updates

- On April 16, 2018, OVERS will update to release 17.3.6.
- Call our OVERS Help Desk if you experience any unexpected changes in functionality.

New Sex Designation Functionality

As of version 17.3.6 of OVERS, all user groups will see an updated sex designation option for birth and death records.

Change: The OVERS system has new options for sex designation. The selections of Female, Male, Undetermined, and Unknown are the same, but you will also see X, X, indicating nonbinary, has been added to include individuals who are not exclusively male.

More Information

- Biometrics
- Login to OVERS
- For State Employees

Contacts

Jennifer Woodward

State Registrar

971-673-1185

Jennifer.A.Woodward@state.or.us

Karen Rangan

Partner Services Manager

971-673-1160

Karen.L.Rangan@state.or.us

Ryan Sanders

Amendments Manager

971-673-1178

Ryan.G.Sanders@state.or.us

Kathy Ellis

OVERS Trainer

971-673-1353

Kathy.Ellis@state.or.us

David Tyner

Certification Manager

971-673-1182

David.w.Tyner2@state.or.us

Marsha Trump

Vital Statistics and Systems
Manager

971-673-1191

Marsha.Trump@state.or.us



971-673-0279

OVERS Enrollment Form - Instructions

This form is available on the Center for Health Statistics web site at:

<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/overs/Pages/NewUsers.aspx>

Use this form to request an Oregon Vital Events Registration System (OVERS) account and gain permission to register death, birth, or fetal death records. A Center for Health Statistics (CHS) employee will notify you by email when your account is created.

If you are a non-signer (funeral home specialists, birth hearing screeners, data entry staff), fax the following:

- 1) OVERS registration application (fill out the top portion of this form completely).
- 2) Two pieces of identification (one piece of identification MUST include a photo).
- 3) A letter from your supervisor granting you permission to access the records associated with your facility.

If you are a signer* (birth certifiers, midwives, funeral directors, medical certifiers, medical examiners), fax the following:

- 1) OVERS registration application (fill out the top portion of this form completely, including your professional license number, if applicable, and check the box next to your role for using OVERS).
- 2) *Birth information specialists and funeral directors only* - A letter from your supervisor granting you permission to access the records associated with your facility.

To certify a record, a biometric device or authenticator app is needed. For a biometric device, you will enroll your fingerprint template at the nearest County Vital Records office or your designated hospital facility OVERS administrator. To register your fingerprints, you must show this form, two pieces of identification and your license number, if applicable. Once your fingerprint template is created, you will be able to sign vital records from any computer as long as a biometric device is installed at your facility (provided to you free of charge by CHS). An authenticator app is another option for certifying records, however it is currently available to medical certifiers, medical examiners and funeral directors only. The authenticator app option does not require fingerprint enrollment.

**In order to sign/certify vital records in Oregon, you must have a position as birth certificate staff in a hospital or licensed birth facility or have a valid professional license legally authorized in Oregon. This includes funeral homes with a reciprocal agreement with WA and medical certifiers licensed in WA, CA, and ID.*

List of Acceptable Identification: *(Social Security Cards are **not** a valid form of identification.)*

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. U.S. Passport 2. Driver's License or ID Card issued by state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 3. ID Card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 4. Certified Copy of a Birth Certificate issued by State, County, Municipal authority or outlying possession of the United States bearing official seal 5. U.S. Military Card or Draft Record 6. Native American Tribal Document 7. U.S. Coast Guard Merchant Mariner Card 8. Military Dependent's ID Card 9. Medical or Hospital Identification Card | <ol style="list-style-type: none"> 10. Certificate of U.S. Citizenship (INS Form N-550 or N-561) 11. Certificate of Naturalization (INS Form N-550 or N-570) 12. Permanent Resident Card or Alien Registration Card with Photograph (INS Form I-151 or I-551) 13. Temporary Resident Card (INS Form I-688) 14. Employment Authorization Card (INS Form I-688A) 15. Reentry Permit (INS Form I-327) 16. Refugee Travel Document (INS Form I-571) 17. Employment Authorization Document issued by the INS which contains a photograph (INS Form-688B) 18. Certification of Birth Abroad issued by the Department of State (Form FS-545 or Form DS-1350) 19. U.S. Citizen ID Card (INS Form I-197) 20. ID Card for use of Resident Citizen on the United States (INS Form I-179) 21. Employment Authorization Document issued by the INS (other than those listed) |
|---|---|

OVERS Enrollment Form
 Fax completed form to: 971-673-1201

Name: _____

Professional Title: MD DO ND PA NP CNM LDM
(First) (M.I.) (Last)

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: Medical Examiner* Medical Examiner Staff

Certification Preference: Authenticator App Biometric Device Both
(The authenticator app option is available to Medical Certifiers, Medical Examiners, and Funeral Directors only)

BIRTH REGISTRATION

Birth User Type: Birth Information Specialist* Birth Clerk Assistant Hearing Screener

COUNTY STAFF

County User Type: County Registrar Deputy Registrar

CHS OFFICE USE ONLY

CHS Official: _____ Date Account Created: _____ Username: _____

Info. complete Setup in OVERS Added to listserv Sent email

COUNTY, FACILITY ADMINISTRATOR OR CHS USE ONLY

Two Types of Identification Shown: **Photo ID** _____ and _____

Date: _____

(County Official/Facility Administrator: Read and sign) I have reviewed the identification documents of the above-named participant and they appear to be genuine. To the best of my knowledge, the participant named above is eligible to sign or certify vital records in Oregon.

Signature of County/State Official/Facility Admin: _____ Print Name: _____

County Official/Facility Administrator - Fax this form to the State office after fingerprint enrollment is complete.

Where To Enroll Your Fingerprints

B

Baker Co. Health Dept.
3330 Pochontas Rd.
Baker City, OR 97814
(541) 523-8211

Benton Co. Health Dept.
Vital Records
530 NW 27th Street
Corvallis, OR 97330
(541) 766-6835

C

Clackamas County
Public Health Division
2051 Kaen Rd. #367
Oregon City, OR 97045
(503) 742-5300

Clatsop Co. Dept. of
Public Health
820 Exchange St., #100
Astoria, OR 97103
(503) 325-8500

Columbia County
Vital Records
230 Strand St.
St. Helens, OR 97051
(503) 397-3796

Coos Co. Health Dept.
Vital Records
281 LaClair Street
Coos Bay, OR 97420
(541) 266-6700

Crook Co. Health Dept.
Vital Records
375 NW Beaver St.,
Ste. 100
Prineville, OR 97754
(541) 447-5165

Curry Co. Clerk's Office
29821 Ellenburg Ave
Gold Beach, OR 97444
(541) 247-3330

D

Deschutes County
Vital Records
2577 NE Courtney Dr.
Bend, OR 97701
(541) 322-7411

D

Douglas County
Clerk's Office
1036 SE Douglas Ave.,
Ste. 124
Roseburg, OR 97470
(541) 440-3513

G

Gilliam County
Clerk's Office
221 S. Oregon
Condon, OR 97823
(541) 384-2311

Grant Co. Health Dept.
Vital Records
528 East Main St., Ste. E
John Day, OR 97845
(541) 575-0429

H

Harney Co. Health Dept.
Vital Records
420 N. Fairview
Burns, OR 97720
(541) 573-2271

Hood River Co. Health
Dept. Vital Records
1109 June Street
Hood River, OR 97031
(541) 386-1115

J

Jackson Co. HHS
140 S. Holly Street
Medford, OR 97501
(541) 774-8000

Jefferson County
Public Health
715 SW 4th St., Ste. C
Madras, OR 97741
(541) 475-4456

Josephine County
Public Health
715 NW Dimmick Street
Grants Pass, OR 97526
(541) 474-5329

K

Klamath County
Public Health
3314 Vandenberg Road
Klamath Falls, OR 97603
(541) 882-8846

L

Lake County Public Health
100 North D St., Ste. 100
Lakeview, OR 97630
(541) 947-6045

Lane County
Public Health
Vital Records
151 W. 7th Ave., Rm 520
Eugene, OR 97401
(541) 682-4640

Lincoln County HHS
255 SW Coast Hwy
Newport, OR 97365
(541) 265-0458

Linn Co. Dept. of Health
2730 Pacific Blvd. SE
Ste. 200
Albany, OR 97321
(541) 967-3888

M

Malheur Co. Health Dept.
1108 SW 4th St.
Ontario, OR 97914
(541) 889-7279

Marion County
Vital Statistics
3180 Center St NE
Salem, OR 97301
(503) 588-5406

Morrow Co. Clerk's Office
100 S Court St. Ste 102
Heppner, OR 97836
(541) 676-5601

Multnomah County
Vital Records
847 NE 19th Ave.
Portland, OR 97232
(971) 988-3745

P

Polk County
Public Health
182 SW Academy Street
Ste. 302
Dallas, OR 97338
(503) 623-8175

S

Sherman
(See Wasco-Sherman Co.)

T

Tillamook Co. Health Dept.
801 Pacific Ave.
Tillamook, OR 97141
(503) 842-3900

U

Umatilla Co. Health Dept.
200 SE 3rd St.
Pendleton, OR 97801
(541) 278-5432

Union County Center for
Human Development, Inc.
2301 Cove Avenue
La Grande, OR 97850
(541) 962-8809

W

Wallowa County
Vital Records
101 S. River St, Rm 103
Enterprise, OR 97828
(541) 426-7755

Wasco-Sherman County
Health Dept.
419 E. 7th Street
The Dalles, OR 97058
(541) 506-2600

Washington County
Vital Records
155 N. First Ave., Rm 170
Hillsboro, OR 97124
(503) 846-3538

Wheeler Co. Health Dept.
Clerk's Office
701 Adams Street, Ste 204
Fossil, OR 97830
(541) 763-2373

Y

Yamhill County
Public Health
412 NE Ford Street
McMinnville, OR 97128
(503) 434-7477