

Appendix D: Sample form — Certificate of Live Birth



CERTIFICATE OF LIVE BIRTH

136-

Center for Health Statistics
Type or print in permanent black ink.
See handbook for instructions.

State File Number

CHILD	1. CHILD — NAME (First, Middle, Other Middle, Last, Suffix)			
	2. SEX	3a. DATE OF BIRTH (Month, Day, Year)	3b. TIME OF BIRTH	4a. COUNTY OF BIRTH
	4b. FACILITY OF BIRTH		4c. CITY, TOWN, OR LOCATION OF BIRTH	
MOTHER	5a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		5b. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)	
	5c. MOTHER'S RESIDENCE — STATE	5d. COUNTY	5e. CITY, TOWN, OR LOCATION	
	5f. STREET AND NUMBER			5g. ZIP CODE
	6a. DATE OF BIRTH (Month, Day, Year)	6b. BIRTHPLACE (State, Territory, or Foreign Country)		
FATHER/ SECOND PARENT	7. FATHER/SECOND PARENT'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			
	8a. DATE OF BIRTH (Month, Day, Year)	8b. BIRTHPLACE (State, Territory, or Foreign Country)		
INFORMANT	9a. INFORMANT'S NAME	9b. INFORMANT'S RELATIONSHIP TO CHILD		
	9c. INFORMANT'S SIGNATURE — I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. SIGNATURE			
CERTIFIER	10a. CERTIFIER'S NAME	10b. CERTIFIER'S TITLE	10c. CERTIFIER'S ADDRESS	
	10d. CERTIFIER'S SIGNATURE — I certify that this child was born alive at the place, time and date stated. SIGNATURE			10e. DATE SIGNED (Month, Day, Year)
	11a. REGISTRAR'S SIGNATURE	11b. DATE FILED (Month, Day, Year)		

MOTHER	12a. WAS HOME DELIVERY PLANNED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		12b. IS ADOPTION/LEGAL PROCEEDING EXPECTED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	13. MOTHER'S MAILING ADDRESS — <input type="checkbox"/> Check if same as Mother's residence, OR:			
	13a. STATE	13b. CITY, TOWN, OR LOCATION	13c. STREET AND NUMBER	13d. ZIP CODE
SSN	13e. RESIDENCE INSIDE CITY LIMITS? (Check appropriate answer) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		13f. PRIMARY TELEPHONE NUMBER	13g. SECONDARY TELEPHONE NUMBER
	14a. REQUEST A SOCIAL SECURITY NUMBER FOR THIS CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No	14b. MOTHER'S — Social Security Number <input type="checkbox"/> Check if none	14c. FATHER/SECOND PARENT'S — Social Security Number <input type="checkbox"/> Check if none	
PARENTAGE	15a. MOTHER MARRIED — at conception, at delivery, or within 300 days prior to birth of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	15b. MOTHER IN OREGON REGISTERED DOMESTIC PARTNERSHIP — at conception, at delivery, or within 300 days prior to birth of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MOTHER	15c. PATERNITY ACKNOWLEDGMENT — If answers to 15a and 15b are "no", has a paternity acknowledgment been signed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	16. EDUCATION (Check highest grade completed)			
	<input type="checkbox"/> 8th grade or less	<input type="checkbox"/> High school diploma or GED	<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Master's degree <input type="checkbox"/> Unknown
	<input type="checkbox"/> 9th–12th grade; no diploma	<input type="checkbox"/> Some college credit but no degree	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Doctorate or Professional degree
MOTHER	17. HISPANIC ORIGIN (Check all that apply)			
	<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Other Hispanic Origin (specify): _____			
FATHER/ SECOND PARENT	<input type="checkbox"/> Yes, Mexican, Mexican-American, Chicana <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Unknown			
	18. RACE (Check all that apply)			
	<input type="checkbox"/> White	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other (specify): _____
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Samoan <input type="checkbox"/> Unknown
FATHER/ SECOND PARENT	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian (specify): _____	
	(specify tribe(s)): _____			
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander (specify): _____	
	19. EDUCATION (Check highest grade completed)			
<input type="checkbox"/> 8th grade or less	<input type="checkbox"/> High school diploma or GED	<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Master's degree <input type="checkbox"/> Unknown	
<input type="checkbox"/> 9th–12th grade; no diploma	<input type="checkbox"/> Some college credit but no degree	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Doctorate or Professional degree	
FATHER/ SECOND PARENT	20. HISPANIC ORIGIN (Check all that apply)			
	<input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Other Hispanic Origin (specify): _____			
MOTHER	<input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Unknown			
	21. RACE (Check all that apply)			
	<input type="checkbox"/> White	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other (specify): _____
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Samoan <input type="checkbox"/> Unknown
MOTHER	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian (specify): _____	
	(specify tribe(s)): _____			
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander (specify): _____	
	22. DID MOTHER GET WIC FOOD? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23. MOTHER'S HEIGHT (feet/inches)	24a. MOTHER'S WEIGHT (Pre-pregnancy) (pounds)	24b. MOTHER'S WEIGHT (At delivery) (pounds)
25. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY		26. ALCOHOL USE DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No		
# per day		If yes, average number of drinks per week?		
3 months before pregnancy # _____ Cigarettes	2nd 3 months of pregnancy # _____ Cigarettes			
1st 3 months of pregnancy # _____ Cigarettes	3rd 3 months of pregnancy # _____ Cigarettes			
27. MOTHER'S MEDICAL RECORD # (optional)	28. MOTHER'S MEDICAID #	29. DATE OF LAST MENSES (Month, Day, Year)		
30. PRINCIPAL METHOD OF PAYMENT			31a. DATE OF 1st PRENATAL CARE VISIT (Month, Day, Year) <input type="checkbox"/> Check if none	
<input type="checkbox"/> Medicaid/Oregon Health Plan	<input type="checkbox"/> Self-pay	<input type="checkbox"/> Champus/Tricare	<input type="checkbox"/> Other (specify): _____	
<input type="checkbox"/> Private insurance	<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> Other government <input type="checkbox"/> Unknown		
31b. TOTAL # OF PRENATAL CARE VISITS	32a. PREVIOUS LIVE BIRTHS (# now living)	32b. PREVIOUS LIVE BIRTHS (# now dead)	32c. DATE OF LAST LIVE BIRTH (Month, Year)	

COMPLETE BACKSIDE OF FORM

45-1 (03/15)

SPACE ABOVE MUST BE LEFT BLANK

33. OTHER PREGNANCY OUTCOMES (<i>Spontaneous and Induced terminations, ectopic pregnancies</i>)		34. MOTHER TESTED FOR HIV?	
33a. COMBINED # OTHER OUTCOMES	33b. DATE OF LAST OTHER OUTCOME (Month, Year)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
35. PREGNANCY RISK FACTORS (<i>Check all that apply</i>)			
<input type="checkbox"/> Diabetes — Gestational <input type="checkbox"/> Diabetes — Pre-pregnancy <input type="checkbox"/> Hypertension — Pre-pregnancy (<i>Chronic</i>) <input type="checkbox"/> Hypertension — Gestational		<input type="checkbox"/> Hypertension — Eclampsia <input type="checkbox"/> Previous Preterm Births (<37 completed weeks gestation) <input type="checkbox"/> Pregnancy resulted from infertility treatment — fertility-enhancing drugs <input type="checkbox"/> Pregnancy resulted from infertility treatment — assisted reproductive technology	
<input type="checkbox"/> Mother had a previous cesarean delivery How many? _____ <input type="checkbox"/> None of the above			
36. MOTHER TESTED FOR: (<i>Check all that apply</i>)	37. INFECTIONS PRESENT and/or TREATED (<i>Check all that apply</i>)	38. OBSTETRIC PROCEDURES (<i>Check all that apply</i>)	39. ONSET OF LABOR
<input type="checkbox"/> Syphilis <input type="checkbox"/> Group B Strep	<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Chlamydia <input type="checkbox"/> None of the above	<input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis <input type="checkbox"/> External cephalic version successful <input type="checkbox"/> External cephalic version failed <input type="checkbox"/> None of the above	<input type="checkbox"/> Premature rupture ≥ 12 hours <input type="checkbox"/> Precipitous labor < 3 hours <input type="checkbox"/> Prolonged labor ≥ 20 hours <input type="checkbox"/> None of the above
40. CHARACTERISTICS OF LABOR AND DELIVERY (<i>Check all that apply</i>)			
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Steroids for fetal lung maturation prior to delivery <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Antibiotics during labor		<input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temp. ≥ 38°C <input type="checkbox"/> Unknown <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above	
41. METHOD OF DELIVERY			
41a. FETAL PRESENTATION AT DELIVERY	41b. FINAL ROUTE AND METHOD OF DELIVERY		
<input type="checkbox"/> Cephalic <input type="checkbox"/> Other <input type="checkbox"/> Breech <input type="checkbox"/> Unknown	<input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> Unknown <input type="checkbox"/> Vaginal/forceps <input type="checkbox"/> Cesarean — If Cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
42. MATERNAL MORBIDITY (<i>Check all that apply</i>)			
<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> 3rd or 4th degree perineal laceration		<input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> None of the above <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> Unknown at this time	
43. MOTHER TRANSFERRED TO THIS FACILITY PRIOR TO DELIVERY?		44. INFANT TRANSFERRED FROM THIS FACILITY AFTER DELIVERY?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility: _____	
45. INFANT'S MEDICAL RECORD # (<i>optional</i>)	46. BIRTH WEIGHT _____ lbs./oz. OR _____ g	47. APGAR _____ 5 min. _____ 10 min.	48. OBSTETRIC ESTIMATE OF GESTATION (<i>weeks</i>)
49. PLURALITY (<i>Single, Twin, Triplet, etc.</i>)	50. BIRTH ORDER (<i>1st, 2nd, 3rd, 4th, etc.</i>)	51. NUMBER BORN ALIVE THIS DELIVERY	52. INFANT ALIVE AT TIME OF REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No
53. INFANT BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No	54. ABNORMAL CONDITIONS OF THE NEWBORN (<i>Check all that apply</i>)		
	<input type="checkbox"/> Assisted ventilation required immediately <input type="checkbox"/> Antibiotics received by newborn for suspected neonatal sepsis <input type="checkbox"/> Assisted ventilation for more than 6 hours <input type="checkbox"/> Seizure/serious neurologic dysfunction <input type="checkbox"/> NICU Admission <input type="checkbox"/> Other significant birth injury <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> None of the above		
55. CONGENITAL ANOMALIES (<i>Check all that apply</i>)			
<input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis		<input type="checkbox"/> Limb reduction defect <input type="checkbox"/> Cleft lip with or without cleft palate <input type="checkbox"/> Cleft palate alone <input type="checkbox"/> Down Syndrome, karyotype confirmed <input type="checkbox"/> Down Syndrome, karyotype pending <input type="checkbox"/> Down Syndrome, karyotype unknown <input type="checkbox"/> Suspected chromosomal disorder, karyotype confirmed <input type="checkbox"/> Suspected chromosomal disorder, karyotype pending <input type="checkbox"/> Suspected chromosomal disorder, karyotype unknown <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above	
56a. WAS HEARING TEST PERFORMED? <input type="checkbox"/> Inpatient <input type="checkbox"/> Refused <input type="checkbox"/> Missed <input type="checkbox"/> Outpatient <input type="checkbox"/> Transfer	56b. TEST DATE (Month, Day, Year)	56c. TEST RESULTS — Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Equipment failure <input type="checkbox"/> Refer <input type="checkbox"/> Physical condition Equipment type used: <input type="checkbox"/> A-ABR <input type="checkbox"/> OAE	56d. TEST RESULTS — Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Equipment failure <input type="checkbox"/> Refer <input type="checkbox"/> Physical condition Equipment type used: <input type="checkbox"/> A-ABR <input type="checkbox"/> OAE
57a. DID INFANT RECEIVE HEPATITIS B VACCINE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	57b. DATE ADMINISTERED (Month, Day, Year)	57c. MANUFACTURER <input type="checkbox"/> Glaxo <input type="checkbox"/> Merck <input type="checkbox"/> Other	57d. LOT NUMBER
58. MOTHER HBsAg+? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Not screened			
59a. DID INFANT RECEIVE HEPATITIS B IMMUNE GLOBULIN (HBIG)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	59b. DATE ADMINISTERED (Month, Day, Year)	59c. MANUFACTURER <input type="checkbox"/> Glaxo <input type="checkbox"/> Merck <input type="checkbox"/> Other	59d. LOT NUMBER

MOTHER

NEWBORN

Appendix D: Sample form — Report of Induced Termination of Pregnancy



REPORT OF INDUCED TERMINATION OF PREGNANCY

Information is **PRIVATE** and **CONFIDENTIAL**

STATE FILE NUMBER _____


TO BE COMPLETED BY PATIENT	1. Patient's ID number: <small>(Patient ID/Facility Chart/Case No.)</small> _____		2. Date termination performed: <small>(Month/Day/Year)</small> _____		3. Patient's age: _____	
	4. Patient's residence address: <small>(City) (County) (State) (Zip)</small> _____				5. Inside city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	6. Date last normal menses began: <small>(Month/Day/Year)</small> _____		7. Clinical estimation of gestational age: _____ Completed weeks			
	8. Previous live births (enter a number or "none"): a. Live births now living: _____ b. Live births now dead: _____		9. Previous terminations (enter a number or "none"): a. Spontaneous Abortions, Miscarriages, Stillbirths, Fetal Deaths: _____ b. Induced Abortions (Do NOT include this termination): _____			
	10. Marital status: <input type="checkbox"/> Never Married <input type="checkbox"/> Now Married <input type="checkbox"/> Declaration of Oregon Registered Domestic Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/Dissolution of Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown					
TO BE COMPLETED BY FACILITY	11. Education: <input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> 9th-12th grade; no diploma <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate or professional degree <input type="checkbox"/> Unknown					
	12. Is patient of Hispanic origin? <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Hispanic Origin (specify): _____			13. Patient's race (select one or more): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (specify tribe(s)): _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify): _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander (specify): _____ <input type="checkbox"/> Other (specify): _____		
	14. Was birth control being used at the time patient became pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify method(s) below (check all that apply): <input type="checkbox"/> Birth Control Pill <input type="checkbox"/> Hormone Implant <input type="checkbox"/> IUD/IUC <input type="checkbox"/> Patch <input type="checkbox"/> Condoms, Prophylactics <input type="checkbox"/> Rhythm <input type="checkbox"/> NuvaRing <input type="checkbox"/> Non-surgical sterilization; e.g., Essure <input type="checkbox"/> Emergency Contraception <input type="checkbox"/> Contraceptive Injection; e.g., Depo-Provera <input type="checkbox"/> Other (specify): _____					
	15. Name of facility where termination occurred: _____					
	16. Location of termination: <small>(City) (County) (State) (Zip)</small> _____					
	17. Primary procedure that terminated this pregnancy (check only one): <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical – Mifepristone <input type="checkbox"/> Other medical (Non-surgical); specify medication(s): _____ <input type="checkbox"/> Dilation and Evacuation (D & E) <input type="checkbox"/> Vaginal Prostaglandin <input type="checkbox"/> Sharp Curettage (D & C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (specify): _____					
	18. Other procedures used for this termination (check all that apply): <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical – Mifepristone <input type="checkbox"/> Other medical (Non-surgical); specify medication(s): _____ <input type="checkbox"/> Dilation and Evacuation (D & E) <input type="checkbox"/> Vaginal Prostaglandin <input type="checkbox"/> Sharp Curettage (D & C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____					
	19. Was follow-up visit recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No			20. Was post-operative/after-care information provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	21. Were there complications at the time of the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify complications (check all that apply): <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration <input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Other (specify): _____					
	22. At time of completion of this report, had follow-up visit occurred at this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify complications (check all that apply): 22a. Complications: <input type="checkbox"/> None <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration <input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Other (specify): _____					
23. At time of completion of this report, had follow-up visit occurred outside this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify location of follow-up visit AND specify complications (check all that apply): 23a. Type of location of follow-up visit: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____ 23b. Complications: <input type="checkbox"/> None <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration <input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____						

PLEASE COMPLETE THIS FORM NO SOONER THAN 2 WEEKS FOLLOWING THE DATE OF TERMINATION.
FORM MUST BE SUBMITTED NO LATER THAN 30 DAYS FOLLOWING THE DATE OF TERMINATION OF PREGNANCY.

(See information on the back side of this form.)

45-113 (01/15)

Appendix D: Sample form — Application, License, and Record of Marriage


136-
 Authority CENTER FOR HEALTH STATISTICS

Local file number **APPLICATION, LICENSE, AND RECORD OF MARRIAGE** State file number

LOCAL OFFICIAL	County:	License effective on or after:	License expires (month, day, year):	
PARTY A: Groom, Bride or Spouse CONSENT FORM WAIVER <input type="checkbox"/> <input type="checkbox"/>	PARTY A is (check one): <input type="checkbox"/> Groom <input type="checkbox"/> Bride <input type="checkbox"/> Spouse			
	1a. Legal name: First		Middle	Last
	1b. Legal name at birth (if different):		1c. Previous name (if different):	
	2. Birthplace (state or foreign country):		3. Date of birth (month, day, year):	
	4. Age (18 or older, 17 with consent):		5. Sex:	
	6. Occupation:		7. Previous marital status (single, widowed, divorced):	
	8a. Father's name (first, middle, legal surname prior to first marriage):		8b. Birthplace (state or foreign country):	
	9a. Mother's name (first, middle, legal surname prior to first marriage):		9b. Birthplace (state or foreign country):	
	10a. Address: Street and number		City or town	State/country
			ZIP	10b. County of residence:
	11. Legal name taken after marriage: First		Middle	Last
PARTY B: Groom, Bride or Spouse CONSENT FORM WAIVER <input type="checkbox"/> <input type="checkbox"/>	PARTY B is (check one): <input type="checkbox"/> Groom <input type="checkbox"/> Bride <input type="checkbox"/> Spouse			
	12a. Legal name: First		Middle	Last
	12b. Legal name at birth (if different):		12c. Previous name (if different):	
	13. Birthplace (state or foreign country):		14. Date of birth (month, day, year):	
	15. Age (18 or older, 17 with consent):		16. Sex:	
	17. Occupation:		18. Previous marital status (single, widowed, divorced):	
	19a. Father's name (first, middle, legal surname prior to first marriage):		19b. Birthplace (state or foreign country):	
	20a. Mother's name (first, middle, legal surname prior to first marriage):		20b. Birthplace (state or foreign country):	
	21a. Address: Street and number		City or town	State/country
			ZIP	21b. County of residence:
	22. Legal name taken after marriage: First		Middle	Last
AFFIDAVIT OF AGE	23. <input type="checkbox"/> Party A — name and address of affiant:			
24. <input type="checkbox"/> Party B — name and address of affiant:				
SIGNATURES	<i>We hereby certify that the information provided is correct to the best of our knowledge and belief and that we are free to marry under the laws of this state.</i>			
25. Party A's legal signature:		Date:	26. Party B's legal signature:	
			Date:	
<i>Neither you nor your spouse is the property of the other. The laws of the State of Oregon affirm your right to enter into marriage and, at the same time, to live within the marriage free from violence and abuse.</i>				
LICENSE TO MARRY	This license authorizes the marriage in this state of the parties named above by any person duly authorized to perform a marriage ceremony under the laws of the State of Oregon.			
27. Date license issued:		28. Signature of issuing official:		
		29. Title of issuing official:		
CEREMONY	30a. Date of marriage:		30b. Where married (city, town or location):	
		30c. County: OREGON		
31a. I certify that the above named persons were married on the date listed above (30a). Signature of person performing ceremony (officiant):			31b. Title:	
31c. Name and address of officiant (person performing ceremony):			31d. Name and address of authorizing religious congregation/organization of officiant:	
Name:			Name:	
Address:			Address:	
Phone:			Phone:	
32. Witness name (print):		33. Witness name (print):		
LOCAL OFFICIAL	34. Signature of county official:		35. Date filed by county official (month, day, year):	

ORS.432.010 required statistical information: The information below will not appear on the certified copies of the record.

36. Party A's Social Security number (specify number, none or unknown):		37. Party B's Social Security number (specify number, none or unknown):	
38. Number of this marriage — first, second, etc. (specify below):	39. If previously married, the date and reason the last marriage ended:		40. Race — OPTIONAL such as Asian, American Indian, African American, White, etc. (specify below):
	By death, divorce, dissolution or annulment (specify below):	Date (month, day, year):	
PARTY A	38a.	39a.	39b.
PARTY B	38b.	39c.	39d.
		40a.	40b.
		41a.	41b.

The authorized person performing this marriage is required to return the original copy of this form to the county clerk within five (5) days following the date of the marriage (ORS 432.173). A penalty may be assessed (ORS 106.990).

Appendix D: Sample form — Declaration of Oregon Registered Domestic Partnership



Oregon Department of Human Services
Center for Health Statistics

136-

Local file number

State file number

Declaration of Oregon Registered Domestic Partnership

This declaration of domestic partnership must be registered with an Oregon county clerk to be valid.

Partner A	1. Partner A – Legal name: First Middle Last						
	2. Surname at birth (if different than current legal name):			3. Other legal surnames used:			
	4. Birthplace (state or foreign country):		5. Date of birth (month, day, year):		6. Age (18 or older):		
	7. Sex:	8. Current status (never married, widowed, divorced):		9a. Resident county:	9b. Resident state:		
	9c. Mailing address: Number and street		City or town		State	Country ZIP code	
	10. Partner A legal name taken after domestic partnership: First Middle Last						
	Partner B	11. Partner B – Legal name: First Middle Last					
		12. Surname at birth (if different than current legal name):			13. Other legal surnames used:		
		14. Birthplace (state or foreign country):		15. Date of birth (month, day, year):		16. Age (18 or older):	
		17. Sex:	18. Current status (never married, widowed, divorced):		19a. Resident county:	19b. Resident state:	
19c. Mailing address: Number and street		City or town		State	Country ZIP code		
20. Partner B legal name taken after domestic partnership: First Middle Last							
Signatures/notaries	I acknowledge that: I am entering into a domestic partnership with the party listed above (Partner B); I am at least 18 years of age; I and/or my partner reside in Oregon and am otherwise capable to enter into this relationship. I declare the information and representations contained herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief. I consent to the jurisdiction of the circuit courts of Oregon for the purpose of an action to obtain a judgment of dissolution or annulment of the domestic partnership or for legal separation of the partners in the domestic partnership, or for any other proceeding related to the partners' rights and obligations, even if one or both partners cease to reside in or to maintain a domicile in this state.						
	Signature partner A (current name) _____ Date _____ State of _____, county of _____. This instrument was acknowledged before me on _____ (date), by _____ (name(s) of person(s)). Signature of notarial officer: _____ Seal: My commission expires: _____						
	I acknowledge that: I am entering into a domestic partnership with the party listed above (Partner A); I am at least 18 years of age; I and/or my partner reside in Oregon; and am otherwise capable to enter into this relationship. I declare the information and representations contained herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief. I consent to the jurisdiction of the circuit courts of Oregon for the purpose of an action to obtain a judgment of dissolution or annulment of the domestic partnership or for legal separation of the partners in the domestic partnership, or for any other proceeding related to the partners' rights and obligations, even if one or both partners cease to reside in or to maintain a domicile in this state.						
	Signature Partner B (current name) _____ Date _____ State of _____, county of _____. This instrument was acknowledged before me on _____ (date), by _____ (name(s) of person(s)). Signature of notarial officer: _____ Seal: My commission expires: _____						
	County of filing:			Signature of county official at county of filing:			
	Date registered at county:			Name of issuing official (print):			
	Local Official						

The information below is optional and will not appear on certified copies of the RECORD.

Partner A	20. Number of this partnership (include marriages and domestic partnerships) 1st, 2nd, etc. (specify below):	21. If previously married or part of a domestic partnership, how did it end? By death, divorce, dissolution or annulment? (specify below)	22. Hispanic origin (if yes, specify):	23. Race(s):	24. Education - highest grade completed (specify below):	25. Occupation:
	20a.	21a.	22a.	23a.	24a.	25a.
Partner B	20b.	21b.	22b.	23b.	24b.	25b.

Appendix D: Sample form — Record of Dissolution of Marriage, Annulment or Registered Domestic Partnership



RECORD OF DISSOLUTION OF MARRIAGE, ANNULMENT OR REGISTERED DOMESTIC PARTNERSHIP

136-

State file number:

The petitioner or legal representative of the petitioner is responsible for completing the personal information on this form and shall present this form to the clerk of the court with the petition. In all cases the completed record shall be a prerequisite to the granting of the final judgment.

Case number: _____			
Judgment type: <input type="checkbox"/> Dissolution of marriage <input type="checkbox"/> Annulment <input type="checkbox"/> Dissolution of registered domestic partnership(RDP)			
Spouse / Partner A	1. Spouse/Partner A – Legal name: (first, middle, last, suffix)		2. Last name at birth: (not required for RDP)
	3. Residence or legal address: (street and number) (city or town) (county) (state)		
	4. Other legal last names used:		
	5. Date of birth: (mm/dd/yyyy)		6. Birthplace: (state, territory or foreign country)
Spouse / Partner B	7. Spouse/Partner B – Legal name: (first, middle, last, suffix)		8. Last name at birth: (not required for RDP)
	9. Residence or legal address: (street and number) (city or town) (county) (state)		
	10. Other legal last names used:		
	11. Date of birth: (mm/dd/yyyy)		12. Birthplace: (state, territory or foreign country)
Marriage / Declaration	13. Date of marriage / filing of RDP declaration: (mm/dd/yyyy)		14. Date couple last resided in same household: (mm/dd/yyyy)
	15a. Place of marriage/RDP: (city, town or location)	15b. County:	15c. State or foreign country:
	16. Number of children under 18 in this household as of the date in item 14: Number: _____ None <input type="checkbox"/>		17. Petitioner: <input type="checkbox"/> Spouse/Partner A <input type="checkbox"/> Spouse/Partner B <input type="checkbox"/> Both
	18a. Name of petitioner's attorney: (print)		
Attorney	18b. Address: (street and number or rural route number, city or town, state, ZIP code)		
	19a. Name of respondent's attorney: (print)		19b. Address: (street and number or rural route number, city or town, state, ZIP code)
Judgment	20. Marriage/RDP declaration of the above named persons was dissolved on: (mm/dd/yyyy)		21. Date judgment becomes effective: (mm/dd/yyyy)
	22. Number of children under 18 whose physical custody was awarded to: ____ Spouse/Partner A ____ Spouse/Partner B ____ Joint (shared custody) ____ Other (specify) _____ <input type="checkbox"/> No children		
	23. County of decree:		24. Title of court: <div style="text-align: center; font-weight: bold;">Circuit</div>
	25. Signature of court official:	26. Title of court official:	27. Date signed: (mm/dd/yyyy)

Information below will not appear on the certified copies of the record.

28. Spouse A's Social Security number: (not required for RDP)				29. Spouse B's Social Security number: (not required for RDP)					
30. Number of this marriage/RDP – first, second, etc.:		31. If previously married or in a RDP date last marriage/RDP ended:		32. Hispanic origin: Cuban, Mexican, Puerto Rican		33. Race(s): Black, White, etc.		34. Education – Specify only highest grade completed:	
By death, divorce, dissolution or annulment (specify below)		Date: (mm/dd/yyyy)		List all that apply (specify below)		List all that apply (specify below)		Elementary/Secondary: ; College: (1-4 or 5+)	
30a. Marriage		30b. RDP		31a.		31b.		32a.	
30c.		30d.		31c.		31d.		32b.	
33a.		33b.		34a.		34b.		34c.	
34a.		34b.		34c.		34d.		34d.	