

Appendix D: Sample Forms

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit

Type or print in permanent black ink
See handbook for instructions

Local File Number

136-

State File Number

CHILD	1. CHILD—NAME First Middle Last			2. SEX	3a. DATE OF BIRTH (Month, Day, Year)	
	3b. TIME OF BIRTH		4a. FACILITY—NAME (If not in hospital, or clinic, give address)		4b. CITY, TOWN, OR LOCATION OF BIRTH	
CERTIFIER	I certify that this child was born alive at the place and time and on the date stated above.					
	5a. SIGNATURE		5b. DATE SIGNED (Month, Day, Year)		5c. CERTIFIER—NAME AND TITLE (Type or print)	
	6a. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)			6b. ATTENDANT MAILING ADDRESS (Street, city or town, state, zip)		
	6c. DATE FILED BY REGISTRAR			6d. REGISTRAR—SIGNATURE		
MOTHER	7a. MOTHER—NAME First Middle Last			7b. MAIDEN SUPNAME	7c. DATE OF BIRTH	7d. STATE OF BIRTH (If not in U.S.A., name country)
	7e. RESIDENCE—STATE		7f. COUNTY	7g. CITY, TOWN, OR LOCATION		7h. STREET AND NUMBER
	7i. RESIDE CITY LIMITS (Yes or no)		7j. ZIP CODE	7k. MOTHER'S MAILING ADDRESS AND ZIP CODE (If same as above, leave blank)		
FATHER	8a. FATHER—NAME First Middle Last			8b. DATE OF BIRTH	8c. STATE OF BIRTH (If not in U.S.A., name country)	
INFORMANT	9. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other informant)					

MOM	DAD	MOTHER		FATHER
		DOB	DOB	SSN
INFORMATION FOR MEDICAL AND HEALTH USE ONLY				
12. Shall abstract of birth certificate be made available for publication or business contact lists? (Check one)				
13. Social Security Number Requested? <input type="checkbox"/> No <input type="checkbox"/> Yes				
14. OF HISPANIC ORIGIN? (Specify No or Yes)		15. RACE—(No. White, Black, American Indian, etc.) (Specify below)		16. EDUCATION (Highest grade completed) Elementary or Secondary (6-12) College (1-4 or 5+)
17. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)		18. HAS A CLOSE RELATIVE OF THIS NEWBORN HAD A HEREDITARY HEARING LOSS THAT EARIED SINCE CHILDHOOD?		
19. APGAR SCORE 1 min. 2 min.		20. BIRTH WEIGHT (Specify units)		
21. PREGNANCY HISTORY (a. Now living, b. Now dead, c. Number, d. None)		21c. DATE OF LAST LIVE BIRTH (Month, Year)		21d. OTHER TERMINATIONS (Spontaneous and Induced)
22. DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		23. PLURAILITY—Single, twin, triplet, etc. (Specify)		24. IF NOT SINGLE BIRTH—Born first, second, third, etc. (Specify)
25. MONTH OF PREGNANCY PRENATAL CARE BEGAN (First, second, etc. (Specify)		26. PRENATAL VISITS—Total number (If none, so state)		
27. SITE - PRENATAL CARE (Check all that apply) Private Clinic/Office, Co. Health Dept., Other Pub. Clinic, Other Site, Private Ins., No Ins., Medicaid (Oregon Health Plan), Other Public Ins.				
28. PRIMARY INSURANCE COVERAGE OF THIS DELIVERY (Check all that apply)				
29. AT TIME OF THIS REPORT WAS NEWBORN ALIVE?		30. NEWBORN REQUIRED INTENSIVE CARE?		31. NEWBORN TRANSFERRED FOR MEDICAL CARE? (If Yes, enter name of facility)
32. MONTHS MOTHER ON WIC PROGRAM (0-9)				
33. MEDICAL FACTORS FOR THIS PREGNANCY (Check all that apply)		34. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)		35. METHOD OF DELIVERY (Check all that apply)
36. ANTENATAL PROCEDURES (Check all that apply)		37. INTRAPARTUM PROCEDURES (Check all that apply)		38. CONGENITAL ANOMALIES OF NEWBORN (Check all that apply)
39. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)		40. CONDITIONS OF THE NEWBORN (Check all that apply)		