
APPENDIX D: SAMPLE FORMS

Appendix D: Sample forms

OREGON DEPARTMENT OF HUMAN SERVICES CENTER FOR HEALTH STATISTICS

136-

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

		Local File Number		State File Number	
CHILD	1. CHILD — NAME	First	Middle	Last	2. SEX
	3a. TIME OF BIRTH	4a. FACILITY — NAME (If not in hospital or clinic, give address)			4b. CITY, TOWN OR LOCATION OF BIRTH
CERTIFIER	5a. I certify that this child was born alive at the place and time and on the date stated above.	5b. DATE SIGNED (Month, Day, Year)			5c. CERTIFIER — NAME AND TITLE (Type or print)
	SIGNATURE				
MOTHER	5d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)	5e. ATTENDANT MAILING ADDRESS (Street, city or town, state, zip)			
	6a. DATE FILED BY REGISTRAR	6b. REGISTRAR — SIGNATURE			
FATHER	7a. MOTHER — NAME	First	Middle	Last	7b. MAIDEN SURNAME
	7c. DATE OF BIRTH	7d. STATE OF BIRTH (If not in U.S.A., name country)			
INFORMANT	8a. RESIDENCE — STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION		8d. STREET AND NUMBER
	8e. INSIDE CITY LIMITS (Yes or no)	8f. ZIP CODE	9. MOTHER'S MAILING ADDRESS AND ZIP CODE (If same as above leave blank)		
	10a. FATHER — NAME	First	Middle	Last	10b. DATE OF BIRTH
					10c. STATE OF BIRTH (If not in U.S.A., name country)
	11. 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)				

		MOTHER	FATHER
INFORMATION FOR MEDICAL AND HEALTH USE ONLY		SSN	SSN
12. Shall abstract of birth certificate be made available for publication or business contact lists? (Check one)		STATE USE ONLY	
13. Social Security Number Requested? <input type="checkbox"/> No <input type="checkbox"/> Yes		a. _____ b. _____ c. _____ d. _____	
14. OF HISPANIC ORIGIN? (Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. EDUCATION (Highest grade completed) Elementary or Secondary (0-12) College (1-4 or 5+)	
15. RACE — (e.g. White, Black, American Indian, etc.) (Specify below)		17. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)	
14a. <input type="checkbox"/> No <input type="checkbox"/> Yes		18. HAS A CLOSE RELATIVE OF THIS NEWBORN HAD A HEREDITARY HEARING LOSS THAT EXISTED SINCE CHILDHOOD? <input type="checkbox"/> No <input type="checkbox"/> Yes	
14b. <input type="checkbox"/> No <input type="checkbox"/> Yes		19. APGAR SCORE 1 min. 5 min.	
20. BIRTH WEIGHT (Specify units)		21. DATE OF LAST OTHER TERMINATION (Month/Year)	
21. PREGNANCY HISTORY		22. CLINICAL ESTIMATE OF GESTATION (Weeks)	
21a. Now living Number _____ None <input type="checkbox"/>		21b. Now dead Number _____ None <input type="checkbox"/>	
23. DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)		24. PLURALITY — Single, twin, triplet, 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)		28. PRIMARY INSURANCE COVERAGE OF THIS DELIVERY (Check all that apply)	
<input type="checkbox"/> Private Clinic/Office <input type="checkbox"/> Co. Health Dept. <input type="checkbox"/> Other Pub. Clinic <input type="checkbox"/> Other Site		<input type="checkbox"/> Private Ins. <input type="checkbox"/> No Ins. <input type="checkbox"/> Medicaid (Oregon Health Plan) <input type="checkbox"/> Other Public Ins.	
29. AT TIME OF THIS REPORT WAS NEWBORN ALIVE? <input type="checkbox"/> No <input type="checkbox"/> Yes		30. NEWBORN REQUIRED INTENSIVE CARE? <input type="checkbox"/> No <input type="checkbox"/> Yes	
31. NEWBORN TRANSFERRED FOR MEDICAL NEED? (If Yes, enter name of facility transferred to) <input type="checkbox"/> No <input type="checkbox"/> Yes		32. MONTHS MOTHER ON WIC PROGRAM? (0-3)	
33. MEDICAL FACTORS FOR THIS PREGNANCY (Check all that apply)		35. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)	
01 <input type="checkbox"/> Anemia (Hct. <30/Hgb<10).....		a. Tobacco use during pregnancy..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	
02 <input type="checkbox"/> Cardiac disease.....		b. Average number cigarettes per day.....	
03 <input type="checkbox"/> Acute or chronic lung disease.....		c. Alcohol use during pregnancy..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	
04 <input type="checkbox"/> Diabetes (Chronic).....		d. Average number drinks per week.....	
05 <input type="checkbox"/> Diabetes (Gestational).....		e. Weight gained during pregnancy..... lbs.	
06 <input type="checkbox"/> Genital herpes.....		f. History available..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	
07 <input type="checkbox"/> Hydramnios/Oligohydramnios.....		g. Other (Specify).....	
08 <input type="checkbox"/> Hemoglobinopathy.....		36. ANTENATAL PROCEDURES (Check all that apply)	
09 <input type="checkbox"/> Hypertension, chronic.....		01 <input type="checkbox"/> Amniocentesis.....	
10 <input type="checkbox"/> Hypertension, pregnancy associated.....		02 <input type="checkbox"/> Tocolytic.....	
11 <input type="checkbox"/> Eclampsia.....		03 <input type="checkbox"/> Ultrasound.....	
12 <input type="checkbox"/> Incompetent cervix.....		04 <input type="checkbox"/> No history available.....	
13 <input type="checkbox"/> Previous infant 4000 + grams.....		00 <input type="checkbox"/> None.....	
14 <input type="checkbox"/> Previous preterm or small for gestational age infant.....		05 <input type="checkbox"/> Other (Specify).....	
15 <input type="checkbox"/> Renal disease.....		37. INTRAPARTUM PROCEDURES (Check all that apply)	
16 <input type="checkbox"/> Rh sensitization.....		01 <input type="checkbox"/> Electronic fetal monitoring.....	
17 <input type="checkbox"/> Uterine bleeding.....		02 <input type="checkbox"/> Induction of labor.....	
18 <input type="checkbox"/> No history available.....		03 <input type="checkbox"/> Stimulation of labor.....	
19 <input type="checkbox"/> Other (Specify).....		00 <input type="checkbox"/> None.....	
34. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)		04 <input type="checkbox"/> Other (Specify).....	
01 <input type="checkbox"/> Febrile (>100° F. or 38° C.).....		38. CONDITIONS OF THE NEWBORN (Check all that apply)	
02 <input type="checkbox"/> Meconium, moderate/heavy.....		01 <input type="checkbox"/> Anemia (Hct. < 39/Hgb. < 13).....	
03 <input type="checkbox"/> Premature rupture of membrane (>12 hours).....		02 <input type="checkbox"/> Birth injury.....	
04 <input type="checkbox"/> Abruptio placenta.....		03 <input type="checkbox"/> Fetal alcohol syndrome.....	
05 <input type="checkbox"/> Placenta Previa.....		04 <input type="checkbox"/> Hyaline membrane disease/RDS.....	
06 <input type="checkbox"/> Other excessive bleeding.....		05 <input type="checkbox"/> Meconium aspiration syndrome.....	
07 <input type="checkbox"/> Seizures during labor.....		06 <input type="checkbox"/> Assisted ventilation (<30 min.).....	
08 <input type="checkbox"/> Precipitous labor (<3 hours).....		07 <input type="checkbox"/> Assisted ventilation (≥30 min.).....	
09 <input type="checkbox"/> Prolonged labor (>20 hours).....		08 <input type="checkbox"/> Seizures.....	
10 <input type="checkbox"/> Dysfunctional labor.....		00 <input type="checkbox"/> None apparent.....	
11 <input type="checkbox"/> Breech/Malpresentation.....		09 <input type="checkbox"/> Other (Specify).....	
12 <input type="checkbox"/> Cephalopelvic disproportion.....		39. METHOD OF DELIVERY (Check all that apply)	
13 <input type="checkbox"/> Cord prolapse.....		01 <input type="checkbox"/> Vaginal.....	
14 <input type="checkbox"/> Anesthetic complications.....		02 <input type="checkbox"/> Vaginal birth after previous C-section.....	
15 <input type="checkbox"/> Fetal distress.....		03 <input type="checkbox"/> Primary C-section.....	
16 <input type="checkbox"/> None.....		04 <input type="checkbox"/> Repeat C-section.....	
17 <input type="checkbox"/> Other (Specify).....		05 <input type="checkbox"/> Forceps.....	
		06 <input type="checkbox"/> Vacuum.....	
		40. CONGENITAL ANOMALIES OF NEWBORN (Check all that apply)	
		01 <input type="checkbox"/> Anencephalus.....	
		02 <input type="checkbox"/> Spina bifida/Meningocele.....	
		03 <input type="checkbox"/> Hydrocephalus.....	
		04 <input type="checkbox"/> Microcephalus.....	
		05 <input type="checkbox"/> Other central nervous system anomalies..... (Specify).....	
		06 <input type="checkbox"/> Heart malformations.....	
		07 <input type="checkbox"/> Other circulatory/respiratory anomalies..... (Specify).....	
		08 <input type="checkbox"/> Rectal atresia/stenosis.....	
		09 <input type="checkbox"/> Tracheo-esophageal fistula/Esoophageal atresia.....	
		10 <input type="checkbox"/> Omphalocele/Gastrostasis.....	
		11 <input type="checkbox"/> Other gastrointestinal anomalies..... (Specify).....	
		12 <input type="checkbox"/> Malformed genitalia.....	
		13 <input type="checkbox"/> Renal agenesis.....	
		14 <input type="checkbox"/> Other urogenital anomalies..... (Specify).....	
		15 <input type="checkbox"/> Cleft lip/palate.....	
		16 <input type="checkbox"/> Polydactyly/Syndactyly/Adactyly.....	
		17 <input type="checkbox"/> Club foot.....	
		18 <input type="checkbox"/> Diaphragmatic hernia.....	
		19 <input type="checkbox"/> Other musculoskeletal/integumental anomalies..... (Specify).....	
		20 <input type="checkbox"/> Down Syndrome.....	
		21 <input type="checkbox"/> Other chromosomal anomalies..... (Specify).....	
		22 <input type="checkbox"/> None apparent.....	
		23 <input type="checkbox"/> Other (Specify).....	

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY 136-

1. NAME OF FACILITY _____		FACILITY CHART OR CASE NO. _____	
2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)		3. DATE TERMINATION PERFORMED: _____ (MONTH) (DAY) (YEAR)	
4. PATIENT'S USUAL RESIDENCE _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS - YES, NO)			
5. AGE LAST BIRTHDAY _____	6. MARITAL STATUS: 1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 5 <input type="checkbox"/> Separated 2 <input type="checkbox"/> Now Married 4 <input type="checkbox"/> Divorced 6 <input type="checkbox"/> Unknown		
7. IS PATIENT OF HISPANIC ORIGIN? 0 <input type="checkbox"/> NO <input type="checkbox"/> YES, specify Cuban, Mexican, Puerto Rican, etc. _____		8. Race (select one or more): 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian 4 <input type="checkbox"/> Chinese 5 <input type="checkbox"/> Japanese 6 <input type="checkbox"/> Hawaiian 8 <input type="checkbox"/> Filipino 0 <input type="checkbox"/> Other Asian <input type="checkbox"/> Other (specify) _____	
9. EDUCATION (Indicate a NUMBER for the HIGHEST grade COMPLETED):		None (0)	Elementary/Secondary (1-12)
			College (1-4, 5+)
10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check "None")			
Live Births		Other Terminations	
a. Now Living Number _____ None 00 <input type="checkbox"/>	b. Now Dead Number _____ None 00 <input type="checkbox"/>	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 <input type="checkbox"/>	d. Induced Abortions (Do <u>not</u> include this termination) Number _____ None 00 <input type="checkbox"/>
11. DATE LAST NORMAL MENSES BEGAN _____ Month Day Year		12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks	
13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 <input type="checkbox"/> NO 2 <input type="checkbox"/> YES; If Yes, specify method below. 1 <input type="checkbox"/> Birth Control Pill 2 <input type="checkbox"/> Foam 3 <input type="checkbox"/> Hormone Implant; e.g., Norplant 4 <input type="checkbox"/> Diaphragm 5 <input type="checkbox"/> IUD 6 <input type="checkbox"/> Condoms, Prophylactics 7 <input type="checkbox"/> Rhythm 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Contraceptive Injection; e.g., Depo Provera			
14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one) 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (Saline/prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 7 <input type="checkbox"/> Hysterotomy/Hysterectomy 8 <input type="checkbox"/> Other (specify) _____			
15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply) 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (saline or prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 8 <input type="checkbox"/> Other (specify) _____			
16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
18. COMPLICATIONS AT TIME OF PROCEDURE (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
19. AT THE TIME OF COMPLETION OF THIS REPORT FORM, HAD A FOLLOW UP VISIT OCCURRED AT THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES; If yes, <u>specify complications</u> (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED OUTSIDE THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> UNKNOWN If yes, <u>specify complications</u> (check all that apply) & <u>complete item 20a</u> below: 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 20A. If yes, specify <u>location of follow-up visit</u> : 1 <input type="checkbox"/> Physician's Office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Other (specify) _____			

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

MAIL TO: Center for Health Statistics
OREGON DEPARTMENT OF HUMAN SERVICES
P.O. Box 14050
Portland, Oregon 97293-0050

(Continued on back)

45-113 (01-07)

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS 136-

Local File Number _____ State File Number _____

APPLICATION, LICENSE, AND RECORD OF MARRIAGE

LOCAL OFFICIAL COUNTY _____ **LICENSE EFFECTIVE ON OR AFTER** _____

GROOM

1. GROOM'S NAME First Middle Last

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, Last) 8b. BIRTHPLACE (State or Foreign Country)

9a. MOTHER'S NAME (First, Middle, Maiden Surname) 9b. BIRTHPLACE (State or Foreign Country)

10. GROOM'S ADDRESS Street and Number City or Town County State Zip

11. If affidavit is required as proof of age, the name and address of the affiant.
 Name: _____ Address: _____

CONSENT FORM WAIVER

BRIDE

12a. BRIDE'S NAME First Middle Last

12b. MAIDEN SURNAME (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, Last) 19b. BIRTHPLACE (State or Foreign Country)

20a. MOTHER'S NAME (First, Middle, Maiden Surname) 20b. BIRTHPLACE (State or Foreign Country)

21. BRIDE'S ADDRESS (Street and Number) City or Town County State Zip

22. If affidavit is required as proof of age, the name and address of the affiant.
 Name: _____ Address: _____

CONSENT FORM WAIVER

SIGNATURES

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.

23. GROOM'S LEGAL SIGNATURE _____ 24. BRIDE'S LEGAL SIGNATURE _____

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.

LOCAL OFFICIAL 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.

25. LICENSE EXPIRES (Month, Day, Year)

26. DATE LICENSE ISSUED 27. SIGNATURE OF ISSUING OFFICIAL 28. TITLE OF ISSUING OFFICIAL

29. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON - MONTH, DAY, YEAR 30a. WHERE MARRIED - CITY, TOWN/LOCATION 30b. COUNTY

OREGON

CEREMONY

31a. SIGNATURE OF PERSON PERFORMING CEREMONY 31b. NAME (Type/print) 31c. TITLE

31d. NAME/ADDRESS OF OFFICIANT'S AUTHORIZING RELIGIOUS CONGREGATION/ORGANIZATION 31e. ADDRESS AND PHONE NUMBER OF PERSON PERFORMING CEREMONY

32. WITNESS NAME 33. WITNESS NAME

LOCAL OFFICIAL

34. SIGNATURE OF COUNTY CLERK OR DIRECTOR 35. DATE FILED BY LOCAL OFFICIAL (Month, Day, Year)

36. GROOM'S SOCIAL SECURITY NUMBER (specify #, none, unknown) 37. BRIDE'S SOCIAL SECURITY NUMBER (specify #, none, unknown)

ORS 432.010
 REQUIRED STATISTICAL INFORMATION. THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD.

38. NUMBER OF THIS MARRIAGE - First, Second, etc. (Specify below)	39. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED (Specify below) By Death, Divorce, Dissolution or Annulment (Specify below)	Date (Month, Day, Year)	40. RACE - OPTIONAL, American Indian, Black, White, etc. (Specify below)	41. EDUCATION (Specify below highest grade completed) Elementary/Secondary College (1-4 or 5+)
38a.	39a.	39b.	40a.	41a.
38b.	39c.	39d.	40b.	41b.

GROOM

BRIDE

THE AUTHORIZED PERSON PERFORMING THIS MARRIAGE IS REQUESTED TO RETURN THE ORIGINAL COPY OF THIS FORM TO THE COUNTY CLERK WITHIN TEN (10) DAYS FOLLOWING THE DATE OF THE MARRIAGE. A PENALTY MAY BE ASSESSED AFTER 35 DAYS. (ORS 106.990)

ORIGINAL - VITAL RECORDS COPY

45-4 (01/02)



136-

State file number:

Record of Dissolution of Marriage or Annulment

Case number: _____

Husband	1. Husband's name: (first) _____ (middle) _____ (last) _____		
	2. Residence or legal address: _____ (street and number) _____ (city or town) _____ (county) _____ (state)		
	3. Date of birth: (mm/dd/yy) _____	4. Birthplace: (state or foreign country) _____	
Wife	5a. Wife's name: (first) _____ (middle) _____ (last) _____		5b. Maiden surname: _____
	6. Former legal names: (if any) _____		
	7. Residence or legal address: _____ (street and number) _____ (city or town) _____ (county) _____ (state)		
	8. Date of birth: (mm/dd/yy) _____	9. Birthplace: (state or foreign country) _____	
Marriage	10a. Place of this marriage: (city, town or location) _____	10b. County: _____	10c. State or foreign country: _____
	11. Date of this marriage: (mm/dd/yy) _____		12. Date couple last resided in same household: (mm/dd/yy) _____
Attorney	13. Number of children under 18 in this household as of the date in item 12: Number: _____ <input type="checkbox"/> None		14. Petitioner: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Both
	15a. Name of petitioner's attorney: (print) _____		15b. Address: (street and number or rural route number, city or town, state, ZIP code) _____
	16a. Name of respondent's attorney: (print) _____		16b. Address: (street and number or rural route number, city or town, state, ZIP code) _____
Decree	17. Marriage of the above named persons was dissolved on: (mm/dd/yy) _____		18. Type of decree: <input type="checkbox"/> Dissolution of marriage <input type="checkbox"/> Annulment
	19. Date decree becomes effective: (mm/dd/yy) _____		
	20. Number of children under 18 whose physical custody was awarded to: Husband: _____ Wife: _____ Joint: (husband and wife) _____ Other: _____ <input type="checkbox"/> No children		
	21. County of decree: _____		22. Title of court: _____
	23. Signature of court official: _____		24. Title of court official: _____
25. Date signed: (mm/dd/yy) _____			

The information below will not appear on certified copies of the record.

26. Husband's Social Security number: (specify number, none or unknown) _____						
27. Wife's Social Security number: (specify number, none or unknown) _____						
Husband	28. Number of this marriage - first, second, etc.: (specify below) _____	29a. If previously married last marriage ended: By death, divorce, dissolution or annulment: (specify below) _____	29b. Date: (mm/dd/yy) _____	30a. Race(s): American Indian, Black, White, etc.: (specify below) List all that apply. _____	31a. Education - Specify only highest grade completed: (specify below) Elementary/ Secondary: (0 - 12) _____	31b. College: 1- 4 or 5+ _____
	28b. _____	29c. _____	29d. _____	30b. _____	31c. _____	31d. _____
Wife						

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 decree.



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		

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: _____

Local Official	County of filing:	Signature of county official at county of filing:
	Date registered at county:	Name of issuing official (print):

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.



136-

RECORD OF DISSOLUTION OF DECLARATION OF REGISTERED DOMESTIC PARTNERSHIP

	Local file number	State file number			
PARTNER A	1. Partner A — Legal name: <i>(First, middle, last, suffix)</i>		2. Other legal surnames used:		
	3. Date of birth: <i>(Month, day, year)</i>		4. Birthplace: <i>(State, territory or foreign country)</i>		
	5. Residence or legal address: Street and number		5a. City, town:	5b. County:	5c. State:
PARTNER B	6. Partner B — Legal name: <i>(First, middle, last, suffix)</i>		7. Other legal surnames used:		
	8. Date of birth: <i>(Month, day, year)</i>		9. Birthplace: <i>(State, territory or foreign country)</i>		
	10. Residence or legal address: Street and number		10a. City, town:	10b. County:	10c. State:
DECLARATION	11. Date declaration of domestic partnership filed: <i>(Month, day, year)</i>		11a. County or state in which filed:		
	12. Date last resided in same household: <i>(Month, day, year)</i>	13. Number of children under 18 years of age in this household as of date in item 12:	14. Petitioner: <input type="checkbox"/> Partner A <input type="checkbox"/> Partner B <input type="checkbox"/> Both		
ATTORNEY	15a. Name of petitioner's attorney:		15b. Address: <i>(Street and number, city or town, state, ZIP code)</i>		
	16a. Name of respondent's attorney:		16b. Address: <i>(Street and number, city or town, state, ZIP code)</i>		
DECREE	17. Declaration of domestic partnership of above named persons was dissolved on: <i>(Month, day, year)</i>		18. Type of decree:		19. Date decree becomes effective: <i>(Month, day, year)</i>
	20. Number of children under 18 whose physical custody was awarded to: <input type="checkbox"/> Partner A <input type="checkbox"/> Partner B <input type="checkbox"/> Joint <input type="checkbox"/> Other <input type="checkbox"/> No children		21. County of decree:		22. Title of court:
	23. Signature of court official:		24. Title of court official:		25. Date signed: <i>(Month, day, year)</i>

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

PARTNER A	26. Number of this domestic partnership- First, second, etc.: <i>(Specify below)</i>	27. If previously married or in a domestic partnership, how did it end? (By death, divorce, dissolution, or annulment) <i>(Specify below)</i>	Date: <i>(Month, day, year)</i>	28. Hispanic origin: <i>(If yes, specify)</i>	29. Race(s): Asian, American Indian or Alaskan Native, White, Black or African American, Native Hawaiian or other Pacific Islander. <i>(Specify below)</i>	30. Education: <i>(Specify below highest grade completed)</i>
	26a.	27a.	27b.	28a.	29a.	30a.
PARTNER B	26b.	27c.	27d.	28b.	29b.	30b.

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 decree.