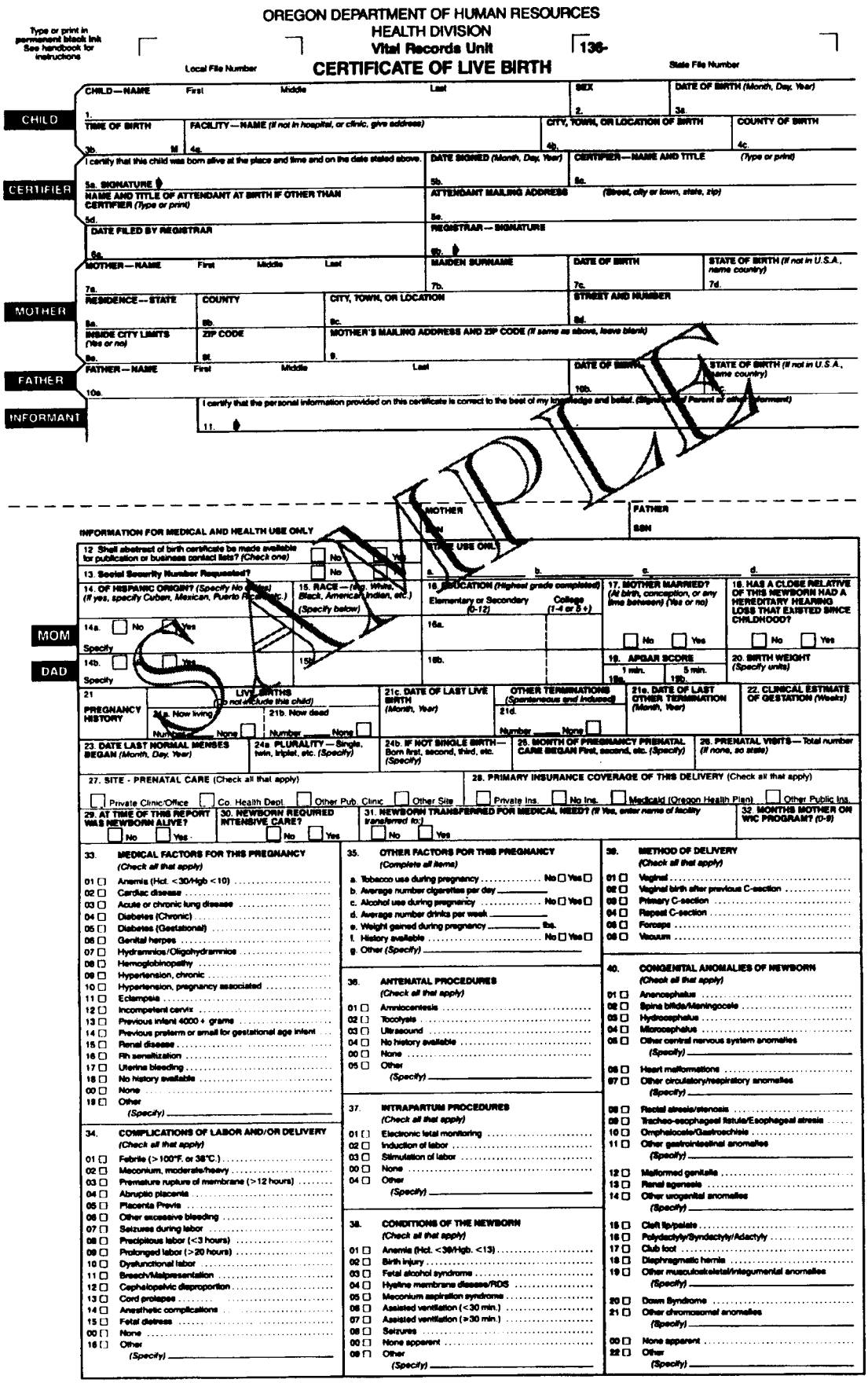
Appendix D: Sample Forms



OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
136-

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

Local File Number

CERTIFICATE OF LIVE BIRTH

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
4c. COUNTY 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)
6a. CERTIFIER — NAME AND TITLE (Type or print)
5d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)
6b. ATTENDANT MAILING ADDRESS (Street, city or town, state, zip)
6d. DATE FILED BY REGISTRAR
6c. REGISTRAR — SIGNATURE

MOTHER
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)
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)

FATHER
10a. FATHER — NAME (First, Middle, Last)
10b. DATE OF BIRTH
10c. STATE OF BIRTH (If not in U.S.A., name country)

INFORMANT
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)
11.

SAMPLE

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER
SSN

FATHER
SSN

MEDICAL USE ONLY
12. Shall abstract of birth certificate be made available for publication or business contact lists? (Check one) ☐ No ☐ Yes
13. Social Security Number Requested? ☐ No ☐ Yes

MOM
14. OF HISPANIC ORIGIN? (Specify No (Not Hispanic), Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)) 14a. ☐ No ☐ Yes Specify
15. RACE — (e.g. White, Black, American Indian, etc.) (Specify below) 15a.
16. EDUCATION (Highest grade completed) a. Elementary or Secondary (0-12) b. College (1-4 or 5+) 16a.
17. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no) ☐ No ☐ Yes
18. HAS A CLOSE RELATIVE OF THIS NEWBORN HAD A HEREDITARY HEARING LOSS THAT EXISTED SINCE CHILDHOOD? ☐ No ☐ Yes

DAD
14b. ☐ No ☐ Yes Specify
15b.
16b.
19. APGAR SCORE 1 min. 19a. 5 min. 19b.
20. BIRTH WEIGHT (Specify units)

21 PREGNANCY HISTORY
LIVE BIRTHS (Do not include this child)
21a. Now living Number None
21b. Now dead Number None
21c. DATE OF LAST LIVE BIRTH (Month, Year)
OTHER TERMINATIONS (Spontaneous and Induced)
21d. Number None
21e. DATE OF LAST OTHER TERMINATION (Month, Year)
22. CLINICAL ESTIMATE OF GESTATION (Weeks)

23. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
24a. PLURALITY — Single, twin, triplet, etc. (Specify)
24b. 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
28. PRIMARY INSURANCE COVERAGE OF THIS DELIVERY (Check all that apply) ☐ Private Ins. ☐ No Ins. ☐ Medicaid (Oregon Health Plan) ☐ Other Public Ins.

29. AT TIME OF THIS REPORT WAS NEWBORN ALIVE? ☐ No ☐ Yes
30. NEWBORN REQUIRED INTENSIVE CARE? ☐ No ☐ Yes
31. NEWBORN TRANSFERRED FOR MEDICAL NEED? (If Yes, enter name of facility transferred to:) ☐ No ☐ Yes
32. MONTHS MOTHER ON WIC PROGRAM? (0-9)

33. MEDICAL FACTORS FOR THIS PREGNANCY (Check all that apply)
01 ☐ Anemia (Hct. <30/Hgb <10)
02 ☐ Cardiac disease
03 ☐ Acute or chronic lung disease
04 ☐ Diabetes (Chronic)
05 ☐ Diabetes (Gestational)
06 ☐ Genital herpes
07 ☐ Hydramnios/Oligohydramnios
08 ☐ Hemoglobinopathy
09 ☐ Hypertension, chronic
10 ☐ Hypertension, pregnancy associated
11 ☐ Eclampsia
12 ☐ Incompetent cervix
13 ☐ Previous infant 4000 + grams
14 ☐ Previous preterm or small for gestational age infant
15 ☐ Renal disease
16 ☐ Rh sensitization
17 ☐ Uterine bleeding
18 ☐ No history available
00 ☐ None
19 ☐ Other (Specify)

34. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
01 ☐ Febrile (>100°F. or 38°C.)
02 ☐ Meconium, moderate/heavy
03 ☐ Premature rupture of membrane (>12 hours)
04 ☐ Abruptio placenta
05 ☐ Placenta Previa
06 ☐ Other excessive bleeding
07 ☐ Seizures during labor
08 ☐ Precipitous labor (<3 hours)
09 ☐ Prolonged labor (>20 hours)
10 ☐ Dysfunctional labor
11 ☐ Breech/Malpresentation
12 ☐ Cephalopelvic disproportion
13 ☐ Cord prolapse
14 ☐ Anesthetic complications
15 ☐ Fetal distress
00 ☐ None
16 ☐ Other (Specify)

35. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)
a. Tobacco use during pregnancy ☐ No ☐ Yes
b. Average number cigarettes per day
c. Alcohol use during pregnancy ☐ No ☐ Yes
d. Average number drinks per week
e. Weight gained during pregnancy lbs.
f. History available ☐ No ☐ Yes
g. Other (Specify)

36. ANTENATAL PROCEDURES (Check all that apply)
01 ☐ Amniocentesis
02 ☐ Tocolysis
03 ☐ Ultrasound
04 ☐ No history available
00 ☐ None
05 ☐ Other (Specify)

37. INTRAPARTUM PROCEDURES (Check all that apply)
01 ☐ Electronic fetal monitoring
02 ☐ Induction of labor
03 ☐ Stimulation of labor
00 ☐ None
04 ☐ Other (Specify)

38. CONDITIONS OF THE NEWBORN (Check all that apply)
01 ☐ Anemia (Hct. <30/Hgb. <13)
02 ☐ Birth injury
03 ☐ Fetal alcohol syndrome
04 ☐ Hyaline membrane disease/RDS
05 ☐ Meconium aspiration syndrome
06 ☐ Assisted ventilation (<30 min.)
07 ☐ Assisted ventilation (>30 min.)
08 ☐ Seizures
00 ☐ None apparent
09 ☐ Other (Specify)

39. METHOD OF DELIVERY (Check all that apply)
01 ☐ Vaginal
02 ☐ Vaginal birth after previous C-section
03 ☐ Primary C-section
04 ☐ Repeat C-section
05 ☐ Forceps
06 ☐ Vacuum

40. CONGENITAL ANOMALIES OF NEWBORN (Check all that apply)
01 ☐ Anencephalus
02 ☐ Spina bifida/Meningocele
03 ☐ Hydrocephalus
04 ☐ Microcephalus
05 ☐ Other central nervous system anomalies (Specify)
06 ☐ Heart malformations
07 ☐ Other circulatory/respiratory anomalies (Specify)
08 ☐ Rectal atresia/stenosis
09 ☐ Tracheo-esophageal fistula/Esophageal atresia
10 ☐ Omphalocele/Gastroschisis
11 ☐ Other gastrointestinal anomalies (Specify)
12 ☐ Malformed genitalia
13 ☐ Renal agenesis
14 ☐ Other urogenital anomalies (Specify)
15 ☐ Cleft lip/palate
16 ☐ Polydactyly/Syndactyly/Adactyly
17 ☐ Club foot
18 ☐ Diaphragmatic hernia
19 ☐ Other musculoskeletal/integumental anomalies (Specify)
20 ☐ Down Syndrome
21 ☐ Other chromosomal anomalies (Specify)
00 ☐ None apparent
22 ☐ Other (Specify)

45-1 (3-95)

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Center for Health Statistics

REPORT OF INDUCED TERMINATION OF PREGNANCY

136-

State File Number

1. NAME OF FACILITY _____

2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)

FACILITY CHART OR CASE NO. _____

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. ☐ Never Married 2. ☐ Now Married 3. ☐ Widowed 4. ☐ Divorced 5. ☐ Separated 6. ☐ Unknown

7. IS PATIENT OF HISPANIC ORIGIN?
0. ☐ NO ☐ YES, specify Cuban, Mexican, Puerto Rican, etc. _____

8. RACE (select one or more): 1. ☐ White 2. ☐ Black 3. ☐ American Indian 4. ☐ Chinese 5. ☐ Japanese 6. ☐ Hawaiian 8. ☐ Filipino 0. ☐ Other Asian ☐ 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 ☐	b. Now Dead Number _____ None 00 ☐	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 ☐	d. Induced Abortions (Do not include this termination) Number _____ None 00 ☐

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. ☐ NO 2. ☐ YES If Yes, specify method below.
1. ☐ Birth Control Pill 2. ☐ Foam 3. ☐ Hormone Implant e.g. Norplant 4. ☐ Diaphragm 5. ☐ IUD 6. ☐ Condoms, Prophylactics 7. ☐ Rhythm 8. ☐ Other, specify _____ ☐ Contraceptive Injection e.g. Depo Provera

14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one)
1. ☐ Suction Curettage 2. ☐ Medical (nonsurgical) specify medication(s) _____ 3. ☐ Dilation and Evacuation (D & E)
4. ☐ Intra-Uterine Instillation (saline/prostaglandin) 5. ☐ Vaginal Prostaglandin 6. ☐ Sharp Curettage (D & C)
7. ☐ Hysterotomy/Hysterectomy 8. ☐ Other (specify) _____

15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply)
0. ☐ None 1. ☐ Suction Curettage 2. ☐ Medical (nonsurgical) specify medication(s) _____
3. ☐ Dilation and Evacuation (D & E) 4. ☐ Intra-Uterine Instillation (saline or prostaglandin) 5. ☐ Vaginal Prostaglandin
6. ☐ Sharp Curettage (D & C) 8. ☐ Other (specify) _____

16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1. ☐ YES 2. ☐ NO

17. WAS FOLLOW-UP VISIT RECOMMENDED? 1. ☐ YES 2. ☐ NO

18. COMPLICATIONS **AT TIME OF PROCEDURE** (check all that apply):
0. ☐ None 1. ☐ Hemorrhage 2. ☐ Infection 3. ☐ Uterine perforation 4. ☐ Cervical laceration
5. ☐ Retained products 6. ☐ Failure of first method 7. ☐ Other (specify) _____

19. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED **AT THIS FACILITY?**
2. ☐ NO 1. ☐ YES, If yes, specify complications (check all that apply):
0. ☐ None 1. ☐ Hemorrhage 2. ☐ Infection 3. ☐ Uterine perforation 4. ☐ Cervical laceration
5. ☐ Retained products 6. ☐ Failure of first method 7. ☐ Other (specify) _____

20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED **OUTSIDE THIS FACILITY?**
2. ☐ NO 1. ☐ YES 3. ☐ UNKNOWN
If yes, specify complications (check all that apply) & complete item 20a below:
0. ☐ None 1. ☐ Hemorrhage 2. ☐ Infection 3. ☐ Uterine perforation 4. ☐ Cervical laceration
5. ☐ Retained products 6. ☐ Failure of first method 7. ☐ Other (specify) _____ 9. ☐ Unknown

20A. If yes, specify location of follow up visit:
1. ☐ Physicians Office 2. ☐ Clinic 3. ☐ Hospital 4. ☐ 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 HEALTH DIVISION
P.O. Box 14050
Portland, Oregon 97293-0050

45-113 (1/99)

TYPE/PRINT IN PERMANENT BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

Local File Number 136- State File Number

APPLICATION, LICENSE, AND RECORD OF MARRIAGE

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
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:

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
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:

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.

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.

25. LICENSE EXPIRES (Month, Day, Year)
26. DATE LICENSE ISSUED 27. SIGNATURE OF ISSUING OFFICIAL ♦ 28. TITLE OF ISSUING OFFICIAL

APPLICANT: DO NOT WRITE BELOW THESE LINES-OFFICIAL USE ONLY

CEREMONY

29. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON - MONTH, DAY, YEAR/TIME
30a. WHERE MARRIED - CITY, TOWN/LOCATON
30b. COUNTY **OREGON**
31a. SIGNATURE OF PERSON PERFORMING CEREMONY ♦ 31b. NAME (Type/Print) 31c. TITLE
31d. COUNTY WHERE AUTHORITY IS RECORDED 31e. ADDRESS OF PERSON PERFORMING CEREMONY
32. WITNESS NAME AND FULL ADDRESS 33. WITNESS NAME AND FULL ADDRESS

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)		40. RACE - OPTIONAL, American Indian, Black, White, etc. (Specify below)	41. EDUCATION (Specify below highest grade completed)	
		By Death, Divorce, Dissolution or Annulment (Specify below)	Date (Month, Day, Year)		Elementary/Secondary (0-12)	College (1-4 or 5+)
GROOM	38a.	39a.	39b.	40a.	41a.	
BRIDE	38b.	39c.	39d.	40b.	41b.	

ORIGINAL-VITAL RECORDS COPY

THE AUTHORIZED PERSON PERFORMING THIS MARRIAGE IS REQUIRED TO RETURN THE ORIGINAL COPY OF THIS FORM TO THE COUNTY CLERK WITHIN TEN (10) DAYS FOLLOWING THE DATE OF THE MARRIAGE.

45-4 (10/99)

306429-00

OREGON DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
Center for Health Statistics

CO. FILE NO. _____

RECORD OF DISSOLUTION OF MARRIAGE, OR ANNULMENT

136- State File Number

TYPE OR PRINT PLAINLY IN BLACK INK

HUSBAND

1. HUSBAND'S NAME *(First, Middle, Last)*

2. RESIDENCE OR LEGAL ADDRESS — STREET AND NUMBER — CITY OR TOWN — COUNTY — STATE

3. SOCIAL SECURITY NUMBER | 4. BIRTHPLACE *(State or Foreign Country)* | 5. DATE OF BIRTH *(Month, Day, Year)*

WIFE

6a. WIFE'S NAME *(First, Middle, Last)* | 6b. MAIDEN SURNAME

7. FORMER LEGAL NAMES (IF ANY) — (1) — (2) — (3)

8. RESIDENCE OR LEGAL ADDRESS — STREET AND NUMBER — CITY OR TOWN — COUNTY — STATE

9. SOCIAL SECURITY NUMBER | 10. BIRTHPLACE *(State or Foreign Country)* | 11. DATE OF BIRTH *(Month, Day, Year)*

MARRIAGE

12a. PLACE OF THIS MARRIAGE—CITY, TOWN OR LOCATION | 12b. COUNTY | 12c. STATE OR FOREIGN COUNTRY | 13. DATE OF THIS MARRIAGE *(Month, Day, Year)*

14. DATE COUPLE LAST RESIDED IN SAME HOUSEHOLD *(Month, Day, Year)*

15. NUMBER OF CHILDREN UNDER 18 IN THIS HOUSEHOLD AS OF THE DATE IN ITEM 14
Number _____ ☐ None

16. PETITIONER
☐ Husband ☐ Wife ☐ Both

ATTORNEY

17a. NAME OF PETITIONER'S ATTORNEY *(Type/Print)* | 17b. ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

18a. NAME OF RESPONDENT'S ATTORNEY *(Type/Print)* | 18b. ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DECREE

19. MARRIAGE OF THE ABOVE NAMED PERSONS WAS DISSOLVED ON *(Month, Day, Year)*

20. TYPE OF DECREE
DISSOLUTION OF MARRIAGE ☐ ANNULMENT ☐

21. DATE DECREE BECOMES EFFECTIVE *(Month, Day, Year)*

22. NUMBER OF CHILDREN UNDER 18 WHOSE PHYSICAL CUSTODY WAS AWARDED TO:
Husband _____ Wife _____
Joint (Husband/Wife) _____ Other _____
☐ No children

23. COUNTY OF DECREE | 24. TITLE OF COURT

25. SIGNATURE OF COURT OFFICIAL | 26. TITLE OF COURT OFFICIAL | 27. DATE SIGNED *(Month, Day, Year)*

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

	28. NUMBER OF THIS MARRIAGE—First, Second, etc. *(Specify below)*	29. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED		30. *RACE—American Indian, Black, White, etc. (Specify below)*	31. EDUCATION *(Specify only highest grade completed)*	
		By Death, Divorce, Dissolution, or Annulment *(Specify below)*	Date *(Month, Day, Year)*		Elementary/Secondary (0-12)	College (1-4 or 5+)
HUSBAND	28a.	29a.	29b.	30a.	31a.	
WIFE	28b.	29c.	29d.	30b.	31b.	

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.

45-5 (11/97)

ORIGINAL—VITAL RECORDS COPY