Appendix D: Sample forms

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

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

136-

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 M | 4a. FACILITY — NAME *(If not in hospital or clinic, give address)* | 4b. CITY, TOWN OR LOCATION OF BIRTH | 4c. COUNTY OF BIRTH

CERTIFIER

5a. I certify that this child was born alive at the place and time and on the date stated above. SIGNATURE | 5b. DATE SIGNED *(Month, Day, Year)* | 5c. CERTIFIER — NAME AND TITLE *(Type or print)*

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

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

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)**

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER SSN | FATHER SSN

12. Shall abstract of birth certificate be made available for publication or business contact lists? *(Check one)* ☐ No ☐ Yes

STATE USE ONLY

13. Social Security Number Requested? ☐ No ☐ Yes

a. _____ b. _____ c. _____ d. _____

MOM

14. OF HISPANIC ORIGIN? *(Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)* | 15. RACE — *(e.g., White, Black, American Indian, etc.) (Specify below)* | 16. EDUCATION *(Highest grade completed)* Elementary or Secondary *(0-12)* 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 EXISTED SINCE CHILDHOOD?

14a. ☐ No ☐ Yes *Specify* | 15a. | 16a. | ☐ No ☐ Yes | ☐ 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 OF 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 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 (>100^0 F. or 38^0 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.< 39/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 (04/05)

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 _____ 3. DATE TERMINATION PERFORMED: _____
(CITY OR TOWN) (COUNTY) (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 ☐ Diaphram 5 ☐ IUD
6 ☐ Condoms, Prophylactics 7 ☐ Rhythm 8 ☐ Other (specify) _____ 9 ☐ 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 ☐ Physician's 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 DEPARTMENT OF HUMAN SERVICES
P.O. Box 14050
Portland, Oregon 97293-0050

(Continued on back)

45-113 (01-07)

TYPE/PRINT IN PERMANENT BLACK INK.

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)

CONSENT FORM WAIVER ☐☐

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 (18 or older, 17 with consent)

16. SEX | 17. OCCUPATION | 18. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced)

CONSENT FORM WAIVER ☐☐

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 BETWEEN THESE LINES – OFFICIAL USE ONLY

CEREMONY

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

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

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 (01/92)

TYPE/PRINT IN PERMANENT BLACK INK

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics

136-

LOCAL FILE NO _____ STATE FILE NUMBER

RECORD OF DISSOLUTION OF MARRIAGE, OR ANNULMENT

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 *(Month, Day, Year)*

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 *(Month, Day, Year)*

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 *(Month, Day, Year)*

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

13. NUMBER OF CHILDREN UNDER 18 IN THIS HOUSEHOLD AS OF THE DATE IN ITEM 12
Number _____ ☐ None

14. PETITIONER
☐ Husband ☐ Wife ☐ Both

ATTORNEY

15a. NAME OF PETITIONER'S ATTORNEY *(Type/Print)*

15b. ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

16a. NAME OF RESPONDENT'S ATTORNEY *(Type/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 *(Month, Day, Year)*

18. TYPE OF DECREE
DISSOLUTION OF MARRIAGE ☐ ANNULMENT ☐

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

20. NUMBER OF CHILDREN UNDER 18 WHOSE PHYSICAL CUSTODY WAS AWARDED TO:
Husband_____ Wife_____
Joint (Husband/Wife)_____ Other_____
☐ No children

21. COUNTY OF DECREE

22. TITLE OF COURT

23. SIGNATURE OF COURT OFFICIAL →

24. TITLE OF COURT OFFICIAL

25. DATE SIGNED *(Month, Day, Year)*

THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD

26. HUSBAND'S SOCIAL SECURITY NUMBER *(Specify #, None, Unknown)*

27. WIFE'S SOCIAL SECURITY NUMBER *(Specify #, None, Unknown)*

	28. NUMBER OF THIS MARRIAGE- First, Second, etc. *(Specify below)*	29. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED: By Death, Divorce, Dissolution, or Annulment *(Specify below)*	29. Date *(Month, Day, Year)*	30. RACE-American Indian, Black, White, etc. *(Specify below)* List All That Apply	31. EDUCATION *(Specify only highest grade completed)* 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 (10/03)

ORIGINAL - VITAL RECORDS COPY