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## **APPENDIX D: SAMPLE FORMS**

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# Appendix D: Sample forms

OREGON DEPARTMENT OF HUMAN SERVICES  
CENTER FOR HEALTH STATISTICS

136- **SAMPLE**

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

Local File Number      **CERTIFICATE OF LIVE BIRTH**      State File Number

<b>CHILD</b>	1. CHILD — NAME (First, Middle, Last, Suffix)	2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Month, Day, Year)
<b>MOTHER</b>	5a. FACILITY — NAME (If not an institution, give street and number)	5b. CITY, TOWN, OR LOCATION OF BIRTH		5c. COUNTY OF BIRTH
	6a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	6b. DATE OF BIRTH (Month, Day, Year)		
	6c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)	6d. BIRTHPLACE (State, Territory, or Foreign Country)		
	6e. RESIDENCE OF MOTHER — STATE	6f. COUNTY	6g. CITY, TOWN, OR LOCATION	
	6h. STREET AND NUMBER	6i. ZIP CODE	6j. INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>FATHER</b>	7a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	7b. DATE OF BIRTH (Month, Day, Year)	7c. BIRTHPLACE (State, Territory, or Foreign Country)	
<b>CERTIFIER</b>	8a. I certify that this child was born alive at the place and time and on the date stated above. SIGNATURE	8b. DATE SIGNED (Month, Day, Year)	8c. CERTIFIER — NAME AND TITLE (Type or print)	
	8d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)	8e. CERTIFIER'S MAILING ADDRESS (Street, City or Town, State, Zip)		
	9a. DATE FILED BY REGISTRAR	9b. REGISTRAR — SIGNATURE		
<b>INFORMANT</b>	10a. 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)	10b. INFORMANT'S RELATIONSHIP TO CHILD		

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**INFORMATION FOR MEDICAL AND HEALTH USE ONLY**

<b>MOTHER</b>	12. MOTHER'S MAILING ADDRESS: <input type="checkbox"/> Same as residence, OR: State: _____ City, Town, or Location: _____ Zip Code: _____ Street & Number: _____			
	13. MOTHER MARRIED (at birth, conception, any time between, or 300 days prior to the birth of the child)? IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. FACILITY'S NPI	
	16. MOTHER'S MEDICAL RECORD NUMBER	17. MOTHER'S SOCIAL SECURITY NUMBER	18. FATHER'S SOCIAL SECURITY NUMBER	
<b>FATHER</b>	19a. OF HISPANIC ORIGIN? (Check "Yes" or "No") (If "yes," specify all that apply, e.g., Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____	20. RACE (Specify all that apply, e.g., American Indian, etc.) 20a. _____ 20b. _____	21. EDUCATION (Highest grade completed) 21a. _____ 21b. _____	
<b>MOTHER</b>	22a. DATE OF FIRST PRENATAL CARE VISIT? (Month, Day, Year) <input type="checkbox"/> No Prenatal Care	22b. DATE OF LAST PRENATAL CARE VISIT? (Month, Day, Year)	22c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY? (If none, enter "0") <input type="checkbox"/> Yes <input type="checkbox"/> NO	
	23. MOTHER'S HEIGHT? (feet/inches)	24. MOTHER'S PRE-PREGNANCY WEIGHT? (pounds)	25. MOTHER'S WEIGHT AT DELIVERY? (pounds)	26. DID MOTHER GET WIC FOOD FOR HERSELF? <input type="checkbox"/> Yes <input type="checkbox"/> NO
	27. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child). 27a. Number Now Living: _____ <input type="checkbox"/> None 27b. Number Now Dead: _____ <input type="checkbox"/> None	28. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous or induced losses or ectopic pregnancies). Number of Other Outcomes: _____ <input type="checkbox"/> None	29. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day. # of cigarettes # of packs Three months before Pregnancy _____ OR _____ First Trimester of Pregnancy _____ OR _____ Second Trimester of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____	
	30. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify) _____	31a. DATE OF LAST LIVE BIRTH (Month, Year)	31b. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)	31c. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
	31d. PLACE WHERE THIS BIRTH OCCURRED (Check one.) <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Birth Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic / Doctor's Office <input type="checkbox"/> Other (Specify) _____	32. ATTENDANT'S NPI	33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, ENTER NAME OF FACILITY FROM WHICH MOTHER WAS TRANSFERRED: _____	
	34. OBSTETRIC PROCEDURES (Check all that apply.) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above	35. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply.) <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions were taken: in-utero resuscitative measures, further fetal assessment, or operative delivery <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above		36. METHOD OF DELIVERY A. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other B. Final route and method of delivery (Check one.) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean: If Cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Was delivery with forceps attempted, but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No D. Was delivery with vacuum extraction attempted, but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No
	37. ONSET OF LABOR (Check all that apply.) <input type="checkbox"/> Premature rupture of the membranes (prolonged $\geq 12$ hours) <input type="checkbox"/> Precipitous labor (<3 hours) <input type="checkbox"/> Prolonged labor ( $\geq 20$ hours) <input type="checkbox"/> None of the above	38. Shall abstract of birth certificate be made available for publication or business-contact lists? (Check one.) <input type="checkbox"/> Yes <input type="checkbox"/> No		

STATE USE ONLY      a. \_\_\_\_\_      b. \_\_\_\_\_      c. \_\_\_\_\_      d. \_\_\_\_\_

**COMPLETE BACKSIDE OF FORM**      45-1 (02/08)

<b>MOTHER</b>		
<p>39. RISK FACTORS IN THIS PREGNANCY (Check all that apply.)</p> <p><input type="checkbox"/> <b>Diabetes</b></p> <p><input type="checkbox"/> Pre-Pregnancy (Diagnosis prior to this pregnancy)</p> <p><input type="checkbox"/> Gestational (Diagnosis in this pregnancy)</p> <p><input type="checkbox"/> <b>Hypertension</b></p> <p><input type="checkbox"/> Pre-Pregnancy (Chronic)</p> <p><input type="checkbox"/> Gestational (PIH, pre-eclampsia)</p> <p><input type="checkbox"/> Eclampsia</p> <p><input type="checkbox"/> Previous preterm birth</p> <p><input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)</p> <p><input type="checkbox"/> Pre-Pregnancy resulted from infertility treatment - If yes, check all that apply:</p> <p><input type="checkbox"/> Fertility-enhancing drugs, artificial insemination or intrauterine insemination.</p> <p><input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</p> <p><input type="checkbox"/> Mother had a previous Cesarean delivery</p> <p>If yes, how many? _____</p> <p><input type="checkbox"/> Alcohol use during pregnancy</p> <p>If yes, average number of drinks per week? _____</p> <p><input type="checkbox"/> None of the above</p>	<p>40. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply.)</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Herpes Simplex (HSV)</p> <p><input type="checkbox"/> None of the above</p>	<p>41. MATERNAL MORBIDITY (Check all that apply.) (Complications associated with labor and delivery)</p> <p><input type="checkbox"/> Maternal transfusion</p> <p><input type="checkbox"/> Third- or fourth-degree perineal laceration</p> <p><input type="checkbox"/> Ruptured uterus</p> <p><input type="checkbox"/> Unplanned hysterectomy</p> <p><input type="checkbox"/> Admission to intensive care unit</p> <p><input type="checkbox"/> Unplanned operating room procedure following delivery</p> <p><input type="checkbox"/> None of the above</p> <p>42. MOTHER TESTED FOR HIV DURING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<b>NEWBORN</b>		
<p>43. NEWBORN'S MEDICAL RECORD NUMBER: _____</p>	<p>44. BIRTH WEIGHT (grams preferred; specify unit)</p> <p>_____ <input type="checkbox"/> grams <input type="checkbox"/> lb/oz</p>	<p>45. OBSTETRIC ESTIMATE OF GESTATION: _____ (completed weeks)</p>
<p>46. APGAR SCORE:</p> <p>Score at 5 minutes: _____</p> <p>If 5-minute score is less than 6,</p> <p>Score at 10 minutes: _____</p>	<p>47. PLURALITY - Single, Twins, Triplets, etc.</p> <p>(Specify) _____</p>	<p>48. IF NOT SINGLE BIRTH - Born First, Second, Third, etc.</p> <p>(Specify) _____</p>
<p>49. IS THE NEWBORN LIVING AT TIME OF REPORT?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Newborn transferred, status unknown</p>		<p>50. IS THE NEWBORN BEING BREAST-FED AT DISCHARGE?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>51. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply.)</p> <p><input type="checkbox"/> Anencephaly</p> <p><input type="checkbox"/> Meningocele/Spina bifida</p> <p><input type="checkbox"/> Cyanotic congenital heart disease</p> <p><input type="checkbox"/> Congenital diaphragmatic hernia</p> <p><input type="checkbox"/> Omphalocele</p> <p><input type="checkbox"/> Gastroschisis</p> <p><input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes)</p> <p><input type="checkbox"/> Cleft Lip with or without Cleft Palate</p> <p><input type="checkbox"/> Cleft Palate alone</p> <p><input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Karyotype confirmed</p> <p><input type="checkbox"/> Karyotype pending</p> <p><input type="checkbox"/> Suspected chromosomal disorder</p> <p><input type="checkbox"/> Karyotype confirmed</p> <p><input type="checkbox"/> Karyotype pending</p> <p><input type="checkbox"/> Hypospadias</p> <p><input type="checkbox"/> None of the anomalies listed above</p>		<p>52. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply.)</p> <p><input type="checkbox"/> Assisted ventilation required immediately following delivery</p> <p><input type="checkbox"/> Assisted ventilation required for more than 6 hours</p> <p><input type="checkbox"/> NICU admission</p> <p><input type="checkbox"/> Newborn given surfactant-replacement therapy</p> <p><input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis</p> <p><input type="checkbox"/> Seizure or serious neurologic dysfunction</p> <p><input type="checkbox"/> Significant birth injury, skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid-organ hemorrhage which requires intervention</p> <p><input type="checkbox"/> None of the above</p> <p>53. WAS NEWBORN METABOLIC SCREENING PERFORMED?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Screening Number _____</p>
<p>54. WAS NEWBORN TRANSFERRED WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF YES, NAME OF FACILITY TO WHICH NEWBORN WAS TRANSFERRED: _____</p>		

SAMPLE

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: \_\_\_\_\_

**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: \_\_\_\_\_

**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)

APPLICANT - DO NOT WRITE BETWEEN THESE LINES - OFFICIAL USE ONLY

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.

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)



136-

State file number:

### Record of Dissolution of Marriage or Annulment

Case number: \_\_\_\_\_

<b>Husband</b>	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) _____	
<b>Wife</b>	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) _____	
<b>Marriage</b>	10a. Place of this marriage: (city, town or location) _____	10b. County: _____	10c. State or foreign country: _____
	11. Date of this marriage: (mm/dd/yy) _____		14. Petitioner: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Both
<b>Attorney</b>	12. Date couple last resided in same household: (mm/dd/yy) _____		13. Number of children under 18 in this household as of the date in item 12: Number: _____ <input type="checkbox"/> None
	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) _____
	17. Marriage of the above named persons was dissolved on: (mm/dd/yy) _____		
<b>Decree</b>	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) _____					
<b>Husband</b>	28a.	28b.	29a.	29b.	30a.
	28c.	28d.	29c.	29d.	30b.
<b>Wife</b>	31a.	31b.	31c.	31d.	

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.**

<b>Partner A</b>	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		

<b>Partner B</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		

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: \_\_\_\_\_  
 My commission expires: \_\_\_\_\_ Seal:

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: \_\_\_\_\_  
 My commission expires: \_\_\_\_\_ Seal:

<b>Local Official</b>	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.

<b>Partner A</b>	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.
<b>Partner B</b>	20b.	21b.	22b.	23b.	24b.	25b.



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**RECORD OF DISSOLUTION OF DECLARATION OF REGISTERED DOMESTIC PARTNERSHIP**

	Local file number	State file number			
<b>PARTNER A</b>	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:
<b>PARTNER B</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:
<b>DECLARATION</b>	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		
<b>ATTORNEY</b>	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>		
<b>DECREE</b>	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.

<b>PARTNER A</b>	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.
<b>PARTNER B</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.